SOME REFLECTIONS ON WAR AND PEACE

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War has been a subject of human interest as far back as any records can be found. A vast literature exists treating the subject from the technical and strategic point of view designed to instruct on how to win wars. An equally extensive literature exists from the legal point of view attempting to inform statesmen, generals and the common man on the circumstances in which, and the methods by which, wars may be justly begun, and how they may be properly conducted. There is an even larger literature of history and belles lettres recounting the motives, causes, and circumstances of wars in the past, or stimulating the readers' emotions and sentiments to favor or oppose a particular war, or war in general. More recently social scientists have sought to utilize all these materials in formulating propositions useful for predicting or controlling war. I will discuss some of the approaches that have been made to this end.

PREDICTION AND CONTROL

We may first distinguish formulations aimed at predicting war from those aimed at controlling war. The distinction, however, is less easy to maintain than is that between pure and applied science in the physical realm. This is true because the conscious efforts men make to control war play a large rôle in estimating its probability, and men's knowledge of the causes of war play a large rôle in the effectiveness of efforts to control it. In other words, the applied science and the pure science are so interdependent that they can hardly be distinguished. This is true of the social sciences generally but particularly of the field of international relations where opinions and stereotypes, though often "erroneous," constitute the "reality" of the subject. Failure to act wisely to preserve peace is an important cause of war and widespread understanding of the causes of war is an important condition of peace(1).

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This interrelationship of the processes of prediction and control has become closer with the shrinking of the world through modern inventions. Among the thousands of primitive tribes that once inhabited the world, the occurrence of war was a function of human drives for dominance, sex, revenge, and territory; of the mores of each particular tribe giving social form and sanction to these drives; of the frequencies of contact among tribes; and of the frequency of occurrences that called for an activation of tribal mores by revenge or war. Among the most primitive tribes war had the character of a ritualistic or formal response to appropriate stimuli rather than of a rational action to acquire power or economic resources. Under these conditions the occurrence of war was like the collision of molecules in a gaseous mixture. No molecule could do much to control the frequency or intensity of such collisions though a mathematically inclined molecule by a proper use of statistical averages might be able to predict the frequency of collisions of different intensity under given conditions(2).

With the advance of civilization, human groups have become larger, their behavior has become less rigidly controlled by custom, their relations with other groups have become more extensive, and their action has been in larger measure governed by rational adaptation of means for the accomplishment of conscious group ends. Since the geographical discoveries at the end of the 15th century, all parts of the world and all civilizations have been brought into continuous contact with one another. The advances of science and technology have increased contacts of all kinds by developing means of rapid global communication and transport, by increasing population and knowledge and by making all peoples vulnerable to military, economic, and propaganda attacks. These conditions have resulted in an embryonic world community of which all peoples are members in the sense of economic and political interdependence although they may be only vaguely

aware of it. Under these conditions, war resembles rebellion in a state. The frequency or intensity of its occurrence in the future cannot be calculated from statistics of the past because the number of instances under like conditions are too few, but it might be controlled by better political and social organization, better education and legislation, better administration and adjudication. All the social sciences can contribute to such improvements(3).

Change in the character of war has been proceeding with accelerating speed. The inventions of the airplane, the radio, and the atomic bomb in our generation have made the 20th century in this respect more different from the 19th than the 19th was from the 2nd. Our job today is less to calculate the probability in a given number of years of a given state being at war, of war occurring between a given pair of states, or of general war occurring, than to create conditions that will prevent war from starting or to devise procedures that will nip it in the bud. If war gets underway it is, under modern conditions, very likely to become world-wide and to threaten the existence of civilization.

Power Politics

In the 19th century wars arose because of disturbances of the balance of power. The system of power politics changed from a purely European to a world-wide system with the development of the power position of the United States and of Japan at the end of the century. A balance of power may be described as a situation in which any state that attempts aggression will be confronted by a spontaneous coalition so powerful as to make the success of its enterprise extremely doubtful. Such spontaneous coalitions tend to develop because each state wishes to continue to exist and appreciates that if it permits a neighbor to become overpowerful, its security will be prejudiced. Consequently, it tends to join others to suppress any one of the states in the system that is threatening to become overpowerful(4).

The balance of power functioned in the 19th century because Great Britain, with a relatively invulnerable position, a dominant navy, a developing economy, a liberal economic policy, and no imperial ambitions in continental Europe, was able to act as balancer. Britain tolerated the wars of Italian and German unification in the mid-nineteenth century and the minor wars of nationalism in the Low Countries and the Balkans. It participated only in the Crimean War to check Russian expansion. The really serious wars of the century were the Civil wars in the United States and China in the mid-century and the Lopez War in the LaPlata area in which Brazil, Argentina, and Uruguay joined to check the expansive disposition of the Paraguayan dictator, practically exterminating the population of Paraguay in the process(5).

Reference to these wars suggests that the balance of power was not so perfect as to convince nationalist movements, whether aimed at the integration of nations or the disintegration of empires, that they could not be successful. There was, in fact, a general opinion among the great powers that such wars were sometimes desirable. In the century between Waterloo (1815) and the Marne (1914), however, there were no efforts by any of the great powers to follow the paths of Charles V, Louis XIV, and Napoleon seeking to realize the medieval idea of universal empire.

The relative stability of the 19th century was shattered by the weakening of the British position; by changes in military technology and the world's economy; by the entry into the system of non-European powers unfamiliar with the nature of power politics; by the increased control of economies by governments reducing the ameliorating influence of free international trade; by the rise of democracy increasing the political influence of industry, agriculture, and labor, with economic and social demands, inconsiderate of the requirements of international politics; and especially by the shrinking of the world making it less possible to localize wars and more dangerous to enter into them. There was no experienced balancer. The pressure for change was greater. The capacity of government to guide foreign policy by balance of power considerations was reduced. Policies of aggression by some were assisted by policies of neutrality by others(6).

The wars of the 20th century can be interpreted as transitional from a system of world order based on the individual policies of sovereign states thinking of their own security and prosperity in preserving the power equilibrium to a system of world order organizing collective efforts to maintain an equilibrium, recognized as a common interest of all. It has been discovered, however, that organized efforts, even though institutionalized as in the League of Nations and the United Nations, will not be reliable unless such a consciousness of world citizenship exists that governments can retain domestic support even if they appear to ignore immediate national interests when necessary to carry out international obligations of collective security. So long as people think as nationalists, exclusively loyal to their states whose sovereignty they cherish, governments, especially governments dependent upon popular support, cannot be relied upon to observe obligations of collective security. A world society resting upon a world public opinion does not yet exist in which reliable institutions of world government can be established.

The result of this disharmony in the needs seen by statesmen and the opinions entertained by peoples has been two world wars of unprecedented destructiveness, and threats of a third that would be fought with atomic weapons. The overwhelming power of the United States and the Soviet Union makes the present power equilibrium extraordinarily unstable. It rests, as Churchill has said, upon mutual fears springing from the realization of the suicidal character of atomic war.

It seems unlikely that the 19th century system of power equilibrium can be restored. There is no potential balancer and there are too few great powers to coalesce effectively against aggression by either of the greatest powers. The problem is to prevent war between Russia and the United States in the short run while efforts proceed to create sufficient consciousness of world citizenship among the people of all nations to make possible world institutions able to prevent war and administer justice. The long-run problem is hampered by the isolationist policy pursued by the Soviet Union. It seeks to prevent its people from communicating or trading with the noncommunist world and from cooperating in the Specialized Agencies of the United Nations. Consequently the conditions of technology and communication that would naturally hasten the development of a world society are prevented from functioning between the two halves of the world. The sparse contact of Soviet representatives with others in the United Nations tends, by the mutual vituperation that it engenders, rather to divide than to unite the world(7).

The problem is difficult, but not hopeless. Understanding of the nature of *international tension,* of *intergroup negotiation,* of *social organization,* and of *political education* may help toward solving both the short-run and the long-run problems. Here social science may aid statesmanship.

Tensions

International tensions develop from rivalry between groups so independent that they can rely only on self-help for survival. These tensions increase with the progress of moral and material preparations by each for defense. In this progress, war seems more and more inevitable to each. The process of irritation, retaliation, and counter-retaliation that has augmented the cold war between Russia and the United States since the Yalta Conference of 1945 illustrates the point.

There are, however, the more fundamental problems: Why should international rivalries exist at all? Why have they arisen between one pair of states, rather than another?

The latter question can usually be answered by reference to history, geography, and politics. Two states may be rivals because there is a historic feud between them that has been periodically alimented by war and new injuries, renewing the spirit of revenge and of mutual hatred. Each generation accepts the feud as natural and inevitable through the versions of national history taught in the schools. Such feuds existed between France and England for centuries, between France and Germany, between England and Ireland, between England and America, between England and Russia, between China and Japan. Feuds seldom exist except between states that are so situated geographically that they can easily injure

one another by invasion or blockade. They also seldom exist unless the general political situation permits each the luxury of feuding without rendering itself vulnerable to some other state or without endangering the loss of a needed ally. England dropped its feuds with France, America, and Russia, and they reciprocated when each began to fear Germany more. France and Germany seem likely to drop their feud if each fears the Soviet Union more. Japan and China might become friends for the same reason had not China become communist. England dropped its feud against Ireland when it saw the need of American friendship, but Ireland continues to feud because it feels protected by America(8).

The situation of the power equilibrium as a whole also exerts an important influence upon the location of rivalries. With the shrinking of the world, this influence becomes more important than that of particular grievances of the past. Systems of power politics tend to polarize about the two most powerful states in the system and that tendency becomes more manifest as the general tension level rises and as the world shrinks through inventions. The two polar states become the principal rivals. Others arrange themselves around these poles in varying degrees of union, protection, alliance, and friendship, fading out into a buffer zone of states that hope to remain neutral. The shrinking of the world tends to diminish the area of this zone.

The question remains, why should rivalries between states exist at all? The answer is to be found less in the external grievances of the states than in their internal composition, conflicts, structure, and policies and in the structure of the supercommunity of which they are all members.

Grievances arise because a state, by accident, negligence, or design, at some time acted in a way that another regards as injurious or dangerous. The closer states are in relation to one another; the more they are financially and commercially interdependent; the more nationals of one are in the territory of another; the more internal overcrowding is believed to require an extension of markets or of sources of raw materials; the more fears of attack are believed to require external bases, strategic areas, strategic materials or alliances; the more likely are grievances to arise. States in close proximity, and nearly all states in the present shrunken and interdependent world are very close to all others, will almost certainly have some grievances against others. It is the continuous business of diplomacy and the United Nations to deal with these grievances. Most of them are dealt with peacefully, but sometimes diplomacy and international organization fail. Any grievance may baffle devices of pacific settlement and become serious if it occurs between states that are already rivals. In such circumstances, it may become a test of strength and neither will yield one jot or tittle of its claim to the other. We are, however, inquiring, why do rivalries arise in the first place? If they didn't exist it would seem that grievances could be dealt with peacefully. Grievances, therefore, are not the cause of rivalries but rather rivalries cause grievances to endanger the peace.

Rivalries seem to arise in part from the internal condition of each state requiring it to find an external enemy to support its internal solidarity. This need originates in psychological processes. Tensions start in the individual human mind(9) because of frustrations and ambivalences consequent upon the early training of the child for social life. Discharge upon parents of the aggressive impulses that arise is suppressed. External scapegoats become the target of hatred and aggression. Furthermore, repressed antisocial feelings may be projected upon others. The more widely the social group expands, the more suppressed aggression exists among its members, the more necessary is an "out-group" to serve as a scapegoat if the solidarity of the "in-group" is to be preserved. This need may be less in a free society, where much internal competition, conflict, and rivalry are possible for the discharge of aggressions, than in an authoritarian society that insists on severe discipline and rigid internal order(10).

This theory is supported by the fact that, among primitive societies, war seems to serve the primary function of manifesting the unity of the in-group and providing a scapegoat for the discharge of antisocial

feelings and actions which, if discharged internally, would disintegrate the group. In many of the small islands of the Pacific, the sparse population is divided between two hostile groups, each of which constitutes an "out-group" for the other(11).

This psychological cause of rivalry, tension, and war might be reduced by systems of education, especially preschool education, that would occasion less ambivalence and frustration than is usually the case today, by systems of economy that would distribute production more equitably, and by systems of society and politics that would give greater assurance to all of opportunities for social advance and recognition. Especially important would be social conditions permitting more of the existing aggressions to be discharged harmlessly in party politics, business competition, or sports, or to be discharged symbolically in artistic, literary, or other cultural activity(12). While the Marxist theory that class rivalries are the sole cause of external aggression is grossly oversimplified, undoubtedly social, economic, and political conditions within the state and tensions in the minds of individuals that arise because of these conditions are an important source of international rivalry, tension, and aggression. If these conditions are not ameliorated among all important states, some will continue to feel the need of an external scapegoat to preserve internal solidarity. To expect universal reform of social conditions is, however, utopian. In a shrinking world where population presses on resources and the speed of social change assures much maladjustment within all societies, it is not to be expected that all serious internal tensions can be avoided. Social reform and education can, however, do much to reduce international rivalries.

This leads us to a second cause of rivalries —the necessary oppositions within a system of sovereign states. So long as states are looked upon as independent of one another and consequently obliged to engage in the maneuvers of power politics if they are to continue to exist, each state will oppose whichever neighbor it believes most likely to attack it. That state will become the scapegoat for displacement of hatreds and projection of aggressions; thus rivalry will develop. Only as states become united in alliances or other supergroups do they cease to be potential enemies and, where contacts are close and power equal, present rivals.

The reasons that have through history led to the subordination of related clans to tribes, of tribes to states, and of states to federations, so that larger areas of cooperation and of authoritative adjudication of disputes have been established, continue to operate, until today the subordination of all states to a world society organized in a world government is urged. Such a society, however, can have no out-group to organize against and consequently it differs from all lesser federations. The process of union, therefore, has tended to stop with the world divided into two groups, each an out-group to the other as in the Pacific islands referred to. Such a bipolar system is the least stable and most dangerous type of power equilibrium. Among large civilizations of the past—Egypt, Mesopotamia, China, India, Rome, Christendom, Islam—such equilibria have usually been ended by a universal conquest or by unsuccessful attempts at such conquest ending in anarchy and disintegration of the civilization. The process in these historic civilizations, however, is not precisely parallel to that which the world faces today because, large and isolated as they were, those civilizations always had barbarians or rivals on their periphery. Though Arnold Toynbee refers to the Roman Empire as a "universal state" it was actually organized against barbarians across the Rhine and the Danube and against rival empires in the Orient. A really universal society must permit the discharge of tensions in the individual human mind and in lesser and larger groups of all kinds within that society itself. It must, therefore, be very flexible and very complex. It must have systems of education that develop some common values and a tolerance of much variety. It must attempt to identify as targets of aggression, not human out-groups, but abstract ideas such as war, disease, social discrimination, and political oppression. The adversary of a universal society, as of universal religions, must be an abstract devil, not a tangible enemy. The difficulty of effecting such a substitution is indicated by the tendency of world

government movements to become North Atlantic Federation movements with the very tangible Soviet Union as adversary. Peace in our age, however, requires a genuine world society to absorb within itself the tensions that individual human minds and all lesser groups must discharge somewhere(13).

Negotiations

The development of such a society takes time, and the vast populations under Soviet rule are subjected to conditions of discipline, oppression, and terror in which tension is probably very great. Amelioration of this condition is, however, hampered by the iron curtain and the continuous fear for their positions and lives of the Soviet élite inducing them to direct the animosities of the vast monolithic society toward the noncommunist world, which is made a universal scapegoat. Sentiments of enmity are reciprocated. As the arms race proceeds, the lines become hardened and the rivalry increases.

What action might the United States take to modify this situation? War, sabotage, preparedness, containment, economic development, political declaration, communication of information, and negotiation are possibilities. Changes may take place within the Soviet Union through internal causes, such as difficulties of succession, revolution, or changes of policy. But the methods referred to seem to constitute the principal possibilities of action by which the United States or other western countries might influence the situation. None of them, however, is very promising.

The initiation of preventive or aggressive war would probably be suicidal and in any case impossible for democracies. Efforts at assassination or sabotage within the Soviet Union would probably be unsuccessful, might precipitate war, and would be even more against the principles of democracy than war. Policies of preparedness and containment have been pursued but they have led to an arms race and an augmentation of tensions, and they might lead to war. They are necessary as defensive precautions but they should not develop programs of a size or character to encourage Soviet belief that the United States intends to attack. Economic development becomes a means of preparedness or containment if the Soviet states are excluded and it requires negotiation if they are to participate. Declarations of pacific intention are certain to be construed as propaganda in an atmosphere of rivalry. The transmission of informational, educational, and even propaganda materials is permitted by the Soviet Union in limited quantities and under strict Soviet censorship. Such efforts without the consent of the Soviet Union, as is possible by radio or distribution of printed material, are looked upon by the Soviet government as sabotage and have led to Herculean efforts at radio jamming, to counterblasts of propaganda, to closer drawing of the iron curtain, and to worsening relations. It is possible that more skillful efforts to transmit information could bring better results even if initiated by single nations. It is even more possible that the United Nations might be able to influence the Russian people directly if it had the resources. But it seems doubtful that such efforts, except insofar as they are consented to by the Soviet government itself, can do much to relieve tensions except in a very long time. Thus the main hope of improving relations lies in negotiation.

Negotiation among rivals whose relations are, in general, hostile can succeed only if there is (1) careful and confidential exploration to determine areas in which there is a genuine common interest or a genuine willingness to bargain, (2) scrupulous limitation of detailed discussion to these areas, (3) realization that agreements will not be reliable unless self-executing in the sense that they are expected to last only as long as there is a mutual interest in observance. It is assumed that the parties differ in most of their views of the future. Consequently agreements are not sanctioned by a general solidarity of interest, by commitment to common principles, or by a sense of good faith. Finally there must be (4) realization that agreements will not be reliable unless they have been genuinely understood and accepted by the highest authorities of each state. Negotiations that assume general opposition between the parties have a resemblance to cartels, armistices, and other agreements made between active belligerents. The

rules of war that govern the making of such agreements insist on precision in observance of formalities, expression of terms, and duration of agreement, and termination on notice if duration was not specified or without notice if violated by the other party(14).

Negotiation even between friendly states differs from legislation within a state or federation, the members of which are assumed to be committed to general cooperation. Negotiation requires secrecy because the publics behind the negotiators, being suspicious of one another, would manifest opinions and insist upon positions preventing concessions and compromises essential to agreement. Legislation, on the other hand, since it is designed to give formal force to the prevailing public opinion, requires continual publicity. If broad international commitments for cooperation are made sincerely, as was hoped to be true of those undertaken in the United Nations Charter, the publics of nations tend to be merged in a superpublic and negotiation may tend toward legislation. It is clear, however, that no such general and sincere commitment for cooperation actually exists in the relations of the Soviet and the West.

Because of the needs of secrecy and of limiting the agenda, negotiation requires limitation of the parties to those whose power position makes their consent indispensable. To democracies, however, committed to democratic principles, nationally and internationally in the United Nations, this requirement presents difficulties. Secret explorations or negotiations between the United States and the Soviet Union would probably be viewed with alarm by other countries that think their interests may be sacrificed for peace. Such negotiations might be regarded as an abandonment by the United States of the progress made toward development of a world public opinion and world democracy in international relations through the United Nations.

Because of the rigidity of the Soviet system, negotiation with subordinates bound by rigorous instruction is usually fruitless, but negotiation at the top level cannot be initiated without public knowledge, which would mean that failure to achieve results might increase suspicions and tensions and make the situation worse than it was before.

In view of these considerations, the prospects of successful negotiation are not good. Discussions either at top level or at lower levels may, however, be a means of exchanging information. Mutual knowledge of the intentions of each of the countries with reference to the other may, in itself, reduce tensions, provided those intentions are not of a belligerent character, as is probably the case. Observers have generally concluded that neither the United States nor the Soviet Union has any intention of making war on the other. The danger arises because of excessive tensions inducing miscalculation or irrational action, or because of mistaken belief by one that the other is about to strike inducing it to act in order to gain the advantage of the initiative. Such misinformation is quite probable on the part of the democracies because of Soviet secretiveness and on the part of the Soviet government itself because of the tendency of the agents of a dictatorship to report what is agreeable to their superiors, rather than what is the fact(15). Each side discounts statements given in public discussion as, for example, in the organs of the United Nations, because it interprets them as propaganda. It is possible that private discussions might convey accurate information which would be believed. This appears to have been the case in the discussions at Teheran and Yalta(16).

Organization

The reduction of tensions through unilateral action by the United States especially in economic development and in suitable preparations with an eye to defense and avoidance of provocation, and through discussions and negotiations between the United States and the Soviet Union, especially to improve mutual information, to discover areas of mutual interest, and to achieve reliable agreements within those areas, appear to be presently practicable steps toward creating conditions of peace. Steps looking to a more distant future lie in the orbit of international organization and political education. Clearly if such efforts extend only to the western powers, they would be looked upon by the

Soviet Union as designed to strengthen the power position of those powers and would augment the arms race. To lay foundations for permanent peace, they must be universal in scope.

The United Nations Charter establishes an international organization formally accepted by both the Soviet Union and the United States. This organization has possibilities of development, but is not now able, because of the veto, to deal authoritatively with disputes or to prevent aggression so far as Soviet-American relations are concerned. The United Nations can deal and has dealt with a number of other disputes and situations effectively, such as those on the Balkan-Greek frontier, in Indonesia, and in Palestine. It is still struggling with the Kashmir and Korean problems.

The United Nations also provides for cooperation among its members on social and economic problems and for the development and maintenance of respect for fundamental human rights and for the development of attitudes and opinions throughout the world suitable for peace. The Economic and Social Council, the Human Rights Commission, Unesco, and the numerous other commissions and technical agencies have produced many reports and passed many resolutions. They have influenced national action by many states. They have also drafted, and gained some adhesions to, certain agreements in these fields. This work, however, is hampered by the refusal of the Soviet Union to join the technical agencies and the uncooperative attitude it has taken toward most of the work of the Economic and Social Council and the commissions.

A great deal of attention has been given to the scientific study of international organization—the machinery and procedures by which it can function most effectively, the conditions of opinion that make its functioning possible, and the processes of reciprocal action and reaction between machinery and opinion by which it can be strengthened. Historical studies of federations, confederations, and leagues suggest that efforts to strengthen the machinery in advance of the development of conditions and opinions that will assure general consent may lead to secession and war. Failure to develop the machinery when economic conditions and public opinion are ripe for it may also lead to war. The problem is to develop organization and opinion step by step in relation to one another. The histories of Swiss and American confederations, of the Holy Roman Empire, the Germanic Confederation, and the German Empire; of the Holy Alliance, the League of Nations, and the United Nations are illustrative and deserve detailed study and analysis, which cannot, however, be attempted here(17).

Education

People are not by nature world citizens. Art must make them so if a stable, just, and prosperous world order is to develop in the shrinking world. The people of the world, therefore, need to be politically educated to understand the nature of the world, to tolerate its varied cultures, governments, and economies, to accept the principles and procedures essential for the functioning of international institutions capable of settling disputes and preventing violence, and to subordinate loyalties to, and the immediate interests of, their nations to those principles and procedures. Such education, particularly as it refers to attitudes and loyalties, must begin at a very early age. At higher levels it involves extensive knowledge and understanding of the culture and history of the peoples of the world and comprehension of the values and institutions to which the peoples of the world must be committed, if a world point of view is to be effective. The methods of political education have been extensively studied, but they cannot be dealt with here(18).

Sociologists analyze the development of societies by distinguishing the processes of extension and intensification of communication and exchange throughout the group, of the development of loyalty to the group as a whole, of the assimilation by the members of the group of some common values, and of the organization of the group so that it can act in certain matters as a unit. These four processes interact upon one another and this interaction contributes to education for citizenship in the group(19).

In the world today, the process of political education for citizenship in the world as a whole is hampered by the iron curtain. The people at the two sides are being educated to citizenship in different worlds, one with its center at Lake Success, and the other with its center in the Kremlin. If abundant communications from both centers were received by people everywhere, these conflicting ideas might be accommodated and perhaps in time assimilated. Loyalty to one world manifesting some of the characteristics of each of these two worlds might develop. Some common standards of value might be universally accepted and an organization of the human race able to achieve the purposes that nearly all states have formally accepted in the United Nations Charter might emerge. Such a development is being worked for continuously in the United Nations, but the process cannot be rapid. Until tensions have been sufficiently reduced to permit of more abundant transnational communication, relations between the United States and the Soviet Union will depend primarily upon intergovernmental discussions and negotiations proceeding on the assumption that the two worlds are in most points opposed. As areas of common interest are discovered, tensions may be reduced and the commitments to cooperate for comprehensive purposes, formally accepted in the United Nations Charter, may permit the reciprocal processes of international organization and political education to build firmer foundations of peace.

BIBLIOGRAPHY

1. Q. Wright. A Study of War. pp. 16, 681 ff, 1358 ff, Chicago, 1942.
2. Ibid., pp. 43, 68, 74 ff, 379.
3. Ibid., pp. 217, 379, 402 ff, 1332 ff.
4. Ibid., pp. 743 ff.
5. Q. Wright. The Historic Circumstances of Enduring Peace. Annual Report, American Historical Association, 1942, vol. 3, p. 364 ff.
6. Q. Wright. The Balance of Power, p. 53 ff, in H. W. Weigert and Vilhjalmur Stefansson, Compass of the World, New York, 1944.
7. Q. Wright. Accomplishments and Expectations of World Organization, Yale Law Journal, 55: 870 ff, August 1946.
8. Q. Wright. A Study of War, pp. 1316, 1328.
9. The Constitution of Unesco declares "that since wars begin in the minds of men, it is in the minds of men that the defences of peace must be constructed."
10. Q. Wright. The Importance of the Study of International Tensions. Unesco, International Social Science Bulletin, p. 90, Spring, 1950.
11. Q. Wright. A Study of War, p. 73.
12. Ibid., pp. 956 ff, 1103 ff, 1218 ff.
13. Ibid., p. 972 ff.
14. Hague Regulations of Land Warfare, 1907, Arts. 32-40; U. S. War Department, Basic Field Manual, Rules of Land Warfare, arts. 215-270.
15. George Kennan. Is War With Russia Inevitable? Readers Digest, March, 1950, p. 6; Q. Wright, ed. A Foreign Policy for the United States, p. 41. Chicago, 1947.
16. E. R. Stettinius, Jr. Roosevelt and the Russians, pp. 140, 295. New York, 1949.
17. Q. Wright. A Study of War, pp. 380, 776, 969, 1018, 1043 ff, 1072, 1284 ff; Recent Trends in the Evolution of the United Nations. International Organization, 2:617 ff, Nov. 1948.
18. Charles E. Merriam. The Making of Citizens. Chicago, 1931.
19. Q. Wright. A Study of War, p. 975; The World Community, p. 5 ff, Chicago, 1948.

WHY STATE HOSPITAL SUPERINTENDENTS FAIL [1]

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The willingness to accept the assigned title for this presentation is attended with considerable risk, and has posed a perplexing problem. The discussion of negative values —and I emphasize that they are values—in the administration of public psychiatric services may help us in understanding ourselves and our problems a bit more. Perhaps a poet, rather than a psychiatrist, can give us the real inspiration for a start. Was it not Burns who wrote,

> "O wad some Power the giftie gie us
> To see oursels as ithers see us!"

Just who are we, in the eyes of some other people, and just why do we fail at times?

Of course a superintendent of a state hospital should be professionally qualified and should have such administrative ability as the office requires in the particular hospital system in which he serves. To state this is to state the obvious to a meeting of men experienced in the field.

But a superintendent must be something else. In saying this I realize full well that I am suggesting additional assumption of responsibility by men who are already, by definition, burdened with plenty of responsibilities. In suggesting it, however, I am merely stating a requirement that will be there, regardless of whether a particular superintendent is man enough and doctor enough to assume it.

What is this something else? It is no more, and no less, than that the superintendent be a man whose conduct and bearing and breadth of thinking and understanding be such as to inspire confidence and respect in the lay public that he serves. It is that lay public that often is thoroughly comfortable in the presence of eccentric and narrow-living entertainers on the screen, shall we say, and equally uncomfortable in the presence of eccentric and narrow-thinking doctors whom they must, willy nilly in the economic nature of things, rely upon for mental disease therapy for themselves or their relatives or their friends.

I would be the last to urge that superintendents now, or at any predictable future date, either be or appear as absolute equivalents of that utterly indefinable thing that we call "normal." I suppose it is a mathematical impossibility to call such a numerical minority a "norm," in any case; be it dentists who are content, unlike most people, to drill teeth, be it surgeons who are content, unlike most people, to cut other people's bodies, or be it the members of our or any other profession whose interests—were they stripped of professional trappings—would be considered odd indeed.

But, allowing for this qualification, I still say that it might be all right for a private practitioner to appear slightly odd. The same might go for physicians on a hospital staff, up to a point. But a superintendent who looks like a screwball, walks like a screwball, and talks like a screwball is bad medicine for the public and bad medicine for the profession. I have seen such, in my travels about the country.

For the opposite, and perhaps the optimum at a realistic level, I would give you a relatively young superintendent of one of the hospitals in Massachusetts. When I was commissioner in that state, he was a thorn in my side—always pressing for improvements far beyond the immediate or current imagination or will of the legislature. He was a man who went in for experimental and research efforts and kept his staff alive with the feeling that they were not only caring for current patients but also struggling for new knowledge through application and testing of the latest procedures. But he always gave me and the public the feeling that he was on top of his job and not searching either the heavens or the depths for some miracle. His bearing was manly and direct and his speech was without affectation. His thinking was broad and understanding. He looked like a

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[1] Read in the Section on Mental Hospitals at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.

[2] Commissioner, Maryland Department of Mental Hygiene, Baltimore, Maryland.

doctor, talked like a doctor, walked like a man, and was a good doctor and a good man.

A superintendent like that, I venture to say, will do more to inspire confidence in the public from which hospital support comes, than any other single thing that could be named. People without knowledge of the hierarchy of organization, or the special operational structure of hospitals, sense the old truth—if the commanding officer is all right, the outfit will be all right. People, after all, run into the "head man" in their travel through life all the way from childhood to retirement. They don't have to be experts on the functions of executives in order to realize that the "head man" sets the tone and spirit of the organization. They feel it, whether or not they think it through.

And they feel it, too, when they run into my second bogeyman, who runs the screwball superintendent a close second. This second and last specific example of my "horribles" is the tired superintendent, the sad-eyed soul of whom we might charitably say that he has been beaten by the long struggle for proper therapy and results; of whom in some cases we might more accurately say that he was beaten before he started and sought, with some of his patients, a refuge from the cruel world that refused to identify itself either with him or with the less recoverable of his patients. The tired superintendent sets the tone of his hospital, and the tone is low—sometimes "mighty low."

One might go on with verbal caricatures of others. For example, the superintendent who lets himself get gradually more interested in his dairy farm or his heating plant or some other improvable fixture or facility and appears to have a little less enthusiasm for the patients and the problem they represent; or the superintendent who appears to be nervous and apologetic because there are still some patients left in the hospital. But the two specific examples will serve my purpose of focusing attention on certain attitudes that are important as negative values.

Perhaps of more far-reaching importance is the broadness of vision and thinking of the superintendent. Certainly he must never forget that the administration of state hospitals is in the realm of state medicine, using the term in its generic sense. It has been so for a hundred years. And, if for no other reason than the economics involved, it is going to be so for another hundred years. It involves the mass aspect of treating and caring for sick people.

Where there is a system of several hospitals, it is of first importance for superintendents to realize that they are part of a team. I know that this is difficult, but failure to realize this fully often leads to disastrous results. Of course, every superintendent who is worth his salt is going to fight for the best for his hospital. That is his main concern, and it should be—within limits.

At the same time, however, he must try to realize that his hospital is not his private czaristic domain, and that it is no more nor less a creature of the state than the next one in the state hospital system. His needs for his hospital have to be interpreted in relation to the needs of the other hospitals, and all of them must submit to some limit of satisfaction in any given legislative period. This would be true even if the governor and every member of the legislature were diplomates in psychiatry. They would soon discover that the sky is not the limit and that psychiatrists are also taxpayers.

Disappointments and mistakes are inevitable in any interpretation of needs of a hospital system. The question for the superintendent is whether a failure to obtain a needed and greatly desired appropriation is going to be a cause for personal discouragement—a lollypop peevishly denied. Is he to be so sensitive—to use a nice, neutral, nondiagnostic word—as to conclude that it is a personal affront, when the evidence and the reality demonstrate to others that it is not?

It also seems to me that some superintendents I have met in my travels have failed to realize a fact that no successful superintendent overlooks. It is this: most of the major judgments and decisions with which they must ultimately reckon, and which are of utmost importance to the welfare of their hospitals and the quality of care for their patients, are going to be made at a nonmedical level. It seems almost too obvious to point out that the members of the general public are not equipped to pass on the niceties of diagnosis, for example, of patients for lobotomy or shock treatment or psychother-

apy. But, for the most part, they are equipped to form a general idea as to whether "they're doing the best for Joe at the state hospital." If the staff members have too impersonal an attitude, the relative is going to say to himself; "Ah, those so-and-so's at the state hospital; they're just a group of amateurs and looking for guinea pigs." And the curious thing about it is that the layman is sometimes right when he makes this particularly human diagnosis.

It is a matter of political mathematics that these impressions are multiplied many thousandfold, and they too often find expression in investigations, in parsimonious appropriations, and in morale-destroying interference by individuals or agencies with side motivations. They are multiplied at a nonmedical level, and all the professional posture in the world cannot prevail against them if the multiplication becomes great enough. The individual who "holds the bag" is the superintendent, and sometimes his superior, at least in the first instance.

Let there be no mistake about this. Nonprofessional people have been making judgments based on political mathematics far longer than psychiatrists in any significant numbers have been making diagnoses. And I suspect that trend will continue for a good many years to come.

I have another thought along this line. All of us, but particularly superintendents, must guard against slipping into overintense preoccupation with the application of specific therapies if that means that we are slighting certain human fundamentals that are also therapies. Long before we had lobotomy or shock or even the more modern forms of psychotherapy, people were able to recover from mental illness and go home. I suspect, and the thought is not original, that loving care and spiritual guidance had something to do with it. Perhaps I should say, love and care and spiritual guidance. It seems to me that there is always the danger in America, with our genius for mechanics, of falling in love with the glamor of the mechanics and forgetting that the service of people—sick people—is the ultimate goal. We must never do this in our field for, in our case, concern for people is part of our method of therapy. Here again, facing stark reality, unless we bear that love and care and spiritual guidance high in our minds, we are in danger of a nonmedical but accurate judgment by people who can have feelings about us and our work, even though they might not be able to articulate a professional opinion on the details of our work.

In addition to all this, there are, of course, the obvious points at which nonmedical but all-important judgments are made. The general appearance of the hospital, the nature of the visitors' reception service, the state of cleanliness, the response to telephone or letter inquiries regarding loved ones, the general spirit of the place—these are very important, be they details or general matters. They all provide the guide to the nonmedical observer as to whether the superintendent—the "head man"—is "on top of his job," whether he is running a "good outfit."

I do not propose that these thoughts, expressed so informally and in such nontechnical language, are all-inclusive for the topic assigned. They are intended only as a basis for further thinking and discussion at this meeting or later meetings, and to focus attention on a few points that have impressed me as being important over the years. Those points, in summary, are:

1. A superintendent should maintain a personal conduct and bearing in professional relations, and breadth of thinking and understanding, to a degree that will inspire confidence in the lay public.

2. State hospital administration is involved in state medicine, with everything which that implies; and in a system of hospitals, the welfare of the group must supersede the desires of any individual superintendent.

3. Many of the major decisions on which hospital programs depend—whether they be therapeutic, research, preventive, or training—are made, and are to be made, at the nonmedical level.

4. The ultimate success or failure of a superintendent and his program is dependent to a fair extent on political mathematics. And that, in turn, is formulated by the patron of the hospital—the lay public.

5. Loving care and spiritual guidance are just as important to sick people today as they were years ago, and they must not be lost sight of in the glamor of the newer drastic therapies.

THE CLINICAL DIRECTOR LOOKS AT THE HOSPITAL SUPERINTENDENT[1]

ADDISON M. DUVAL, M. D., WASHINGTON, D. C.

The American Psychiatric Association has approved standards that require that the superintendent of a mental hospital should be a well-qualified physician, an experienced psychiatrist with administrative ability, preferably a diplomate of the American Board of Psychiatry and Neurology, and that he should not be subject to political control. These standards are much too brief to describe the characteristics of a superintendent, which mean so much to the clinical director's happiness and peace of mind. Today I have been given the assignment to discuss some of the characteristics that the clinical director would like to see when he looks at the superintendent. It has been my privilege to work under two superintendents who were internationally known for the excellence of their hospital administration. These two men were William A. White and Winfred Overholser and the hospital was Saint Elizabeths in Washington, D. C. In this respect, I have no doubt been more fortunate than the average clinical director.

Most clinical directors properly aspire to be hospital superintendents some day and many may say to themselves, "The hospital then will be run as it *should* be." I am sure the superintendents present will immediately recognize this thinking as wishful in character and the mechanism really one of healthy catharsis, of "blowing off steam," for we all like to gripe at the superintendent (behind his back!) and take pokes at his methods and decisions, intimating at the same time, of course, that if we were superintendent the "right solution" would have been found. Someone has suggested that a good superintendent can accept such blowing off of steam without feeling scalded. He will realize that it takes more than young ambition or wishful thinking to prepare for his job. It takes a toughness of fiber, a willingness to fight for what he wants, and a skin that is thick enough to withstand unfair criticism, plus knowledge of the work to be done and a fine sense of the correct proportions between the job and the people who work at it. He will realize that his training and years of seasoning have produced a broad tolerance toward the impulsive changes that young clinical directors so often urge before they get seasoned into their job.

All of us realize that it is the superintendent who sets the atmosphere for the entire hospital. He will usually handle its public relations; and the breadth of his information, the appeal of his public statements, his success with the press, and his interest in the broad problems of the community will determine his personal and professional stature as well as the healthy acceptance of his hospital by the public. The clinical director usually knows his superintendent intimately and well, but this relationship should never be so intimate that personal feelings rather than sound professional judgments prevail. On the other hand, because of the close relationship with the superintendent, the clinical director may be in a position to comment pertinently on some of the strengths and weaknesses in the administration of a hospital, as well as to outline some of the characteristics that the clinical director likes to find in his superintendent.

A clinical director has great admiration for the superintendent who has a strong sense of personal discipline, who is confident of his own ability, who acts with quiet deliberateness when the going is rough, and who can say yes or no without any evidence of intending to reflect on the motivations behind the request. He is not happy with the superintendent who cannot make decisions, who procrastinates, makes excuses, passes the responsibility elsewhere, or makes repeated delaying maneuvers. This type of reaction is deadly for the staff and staff function will rapidly deteriorate to a point of complete stagnation.

The superintendent should be a firm be-

[1] Read in the Section on Mental Hospitals at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.

liever in staff organization. He must know the work to be done and be able to match the right person with the right job. The units in his hospital organization must have their responsibilities and duties clearly defined within the hospital policy. If not, the clinical director is sterile in his primary function of technical supervision and direction. After staff responsibilities are determined, the superintendent should by all means delegate proper responsibility to his staff to carry out their duties. Nothing is more frustrating than to get into a situation where one has the duties assigned but no delegated authority to carry them out, so that he must keep running to the superintendent for permission for this minor thing or that. In the eyes of his staff, such a situation reduces the clinical director's status to that of a messenger for the superintendent, and completely stifles his ambition and initiative. Delegation of responsibility by the superintendent to a well-organized staff permits him to have time for over-all planning and policy, for developing broad public relations, for educating the legislature concerning the needs of his hospital, and time for his professional contacts with state and national organizations and societies, which are so essential to a successful superintendent's administration. Under no condition should a superintendent allow himself to get so bogged down with the many routine details of his daily work that he has no time for these broader aspects of his job. These routine details he should and must delegate, even though occasionally it may be painful to give them up because of his personal enjoyment in their completion.

No efficient superintendent has time for the less important time-consuming routine personnel work of the hospital. He must turn to modern, up-to-date personnel practices even though some of these seem revolutionary. Many questions must be answered. How are employees selected at the various staff levels? Is there a proper screening process? Are the various job requirements written out clearly and concisely? Are proper assignments regularly made? Are proper orientation courses given? Is training adequate? Is there arrangement for regular promotion of employees? For sick benefits and retirement? For attention to employee complaints and to constructive suggestions? Special attention should be given to the health and working conditions of all employees. All these are important aspects of good personnel practice and must be given high-level attention by the superintendent if good morale is to be attained and maintained. The details of such program can be worked out quite well by the personnel officer but only if the principal policies have the approval, interest, and support of the superintendent. However, he should always be available to an aggrieved employee—through channels. Final word on the dismissal of an employee is his.

The superintendent should not talk and act as if he were a god who makes no mistakes. He should be very willing to admit his mistakes openly and frankly. If he does not he will soon lose the respect of his staff, for certainly they know well what errors of judgment he has made. If he tries to cover up his errors by some defensive maneuver he will not only lose the trust of his staff but they may take some little pleasure in letting him "take it in the neck" the next time. Of course, such willingness to admit mistakes should not be carried to the extreme, or the superintendent may find he is being very indecisive, showing that he lacks confidence in himself. Directness, assertiveness, and intellectual honesty in interpersonal relationships always pay good dividends.

The superintendent should ask himself if he is ambitious, properly motivated, and sincerely interested in raising his personal prestige as well as that of his hospital. If so, he cannot help being energetic, always making plans for progress, willing to take therapeutic chances with new techniques, willing to risk some temporary losses here or there in order to establish long-range efficient business practices, and always fostering eclecticism as a considered administrative and medical must. How fortunate is the clinical director who works under such a superintendent!

It might be well for the superintendent to ask himself if he would prefer to have some other medical job than the one he holds. If he would, he can never be the success he could be if he felt sincerely that he would not change his job for any other in the hospital. It is possible for a superintendent to have been pushed into the job somewhat

against his desires and better judgment. I personally know one such instance where fortunately the incumbent soon realized he was much happier as a clinical director and actually got permission to give up the superintendency and return to his old job of being a successful clinician. Needless to say, he is now happy again.

The superintendent should be available to the staff, particularly the junior staff, for discussion of their personal problems and plans if they wish such advice (and they sometimes do!).

A good superintendent is always willing to see members of his staff move on to greener pastures. Such an attitude may seem strange at first glance, for changing staff causes disruptions. However, in the long run the policy pays off, since many young ambitious psychiatrists are recommended to the hospital by the previous staff members and the return on the investment in such policy is quite substantial.

Finally, the superintendent should ask himself the sixty-four dollar question, "Do new employees join the hospital because the staff has recommended their working conditions?" If so, the superintendent's administration is a success, his hospital is a good hospital, people are proud to work there, morale is high, and humane care and treatment of the patient is paramount. How proud is the clinical director in looking at such a superintendent, and how satisfactory their relationship!

WHAT THE NURSE LOOKS FOR IN THE ADMINISTRATOR [1]

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First and of foremost importance, the nurse looks for a competent physician in the administrator. In recent years there appears to be a growing tendency to appoint business men as hospital administrators. No one doubts that hospitals need to have good business policies. That much of the time and energy of the superintendent is frequently taken up with budgets, contracts, and like matter is to be deplored, but to place a business executive in charge all too often leads to an overshadowing of the philosophy of medicine, the high humanitarianism synonymous with medicine through the ages, while the patient becomes an object seen through the dollar sign.

This has grave implications for the nurse and nursing. The following serves to illustrate this problem. The Director of Nurses of one of our well-known institutions operating a medical school and a school of nursing recruited a large class of nurse applicants, specifying among other things that there would be a small stipend paid to each student as had been customary. In the meantime the lay administrator learned that many schools do not pay a stipend and, without the knowledge of the Director of the School of Nursing, published that he was making a saving to the hospital by eliminating all student stipends. In so doing he eliminated the incoming class. It is the writer's belief that a class could have been recruited without the stipend, but such business methods destroy confidence. One cannot campaign under one banner and operate under another.

This brings our discussion to the plan of operation and the place of nursing therein. Nurses have long striven to meet the needs of the physician, and that they are not always able to do so is not infrequently because they do not know what those needs are in the administrator's view. Therefore, it is proposed that the most effective procedure is first to have a plan of action, based upon sound philosophy, and that the nurse have a part in the plan or at least a working knowledge of it. Even in this enlightened age there are still those who regard the nurse as one whose duty is "not to reason why." Such an approach cheats the administrator of one of his greatest assets. Nurses today are, on the whole, well-prepared, intelligent women, but if the administrator insists upon keeping the nurse in the dark, always navigating without a chart or the compass of his greater wisdom to steer by, he is inevitably doomed to suffer from her confusion, lost motion, and trial and error methods. This is by no means to be construed as intimating that the nurse wishes or should be given greater voice or authority than her position indicates. In simple terms the thesis submitted is that the administrator determine the type of medical and nursing program he wishes carried forward and, by giving the nurse a thorough knowledge of that plan, obtain more intelligent day-by-day support and cooperation. Having been oriented to the general philosophy and methods of operation, the nurse expects her sphere of action to be outlined in broad terms of the over-all program.

Assuming that she is intelligent and well prepared for the work she is undertaking, she will appreciate being permitted, within the established limitations, to use her own initiative and judgment, realizing, of course, that she is at all times accountable to the administrator or his designate. Such an atmosphere presents a challenge and stimulates the nurse to put forth her best effort at all times. She develops daily in breadth and strength, carrying her staff with her, achieving the objectives she has set for herself as a part of the total purpose of the administrator. Whatever her assets and liabilities, she will give a better performance if she works as one of a team striving toward accepted objectives. In other words, the nurse hopes to be given her assignment and allowed certain freedom in carrying it out, with the assurance that she has the support of the administrator, because they share a common

[1] Read in the Section on Mental Hospitals at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.

cause. On occasion one sees the opposite point of view, where the administrator insists upon an authoritative policy and personally manages those under his jurisdiction, including nurses. Under such a régime the abilities of the nurse tend to atrophy from disuse and she deteriorates on the job or she comes into such acute conflict with management that she is lost to the service.

If a nurse is successful in maintaining good nursing care and/or a school, she expects and is entitled to a certain measure of credit. Equally she should be willing to take the responsibility for her failures, and she should profit by an honest appraisal of her work. Praise unmerited is as damaging as criticism undeserved. Both, if persistent, ultimately destroy the individual. The administration should be such that no department or individual is singled out for special consideration at the expense of other departments or individuals.

Because administrators are human beings and therefore not infallible, the writer is of the opinion that many more are guilty of this than is generally believed and certainly than they themselves recognize. Nursing is not always the department discriminated against, but to be favored over others is to be penalized in the long run. Nursing is only one of many departments of concern to the administrator and, as such, should receive due consideration—no more, and no less. As indicated elsewhere and repeated here for emphasis, the nurse should have an appraisal of her accomplishments and failures as seen by the administrator, for in the final analysis it is his evaluation of her services that counts.

Notwithstanding the increasing academic preparation of the nurse today, the fact remains that the nurse learns all along the line from the doctor; therefore, as a rule she comes to her job eager to please, to work with and for the physician, and to respect authority because she has been fashioned by experience in that pattern.

One hears much of security on all sides today, but the only genuine security that gives peace of mind is that which comes from the knowledge that at the top stands an honest and fearless administrator who will not lull the nurse into a false sense of security while recognizing that her performance is not up to his standard. The nurse has no right to expect the administrator to do her thinking for her, but she should have the right to know how closely her ideas and her performance approximate his expectations of her. Economic security and professional reputation would rarely be in jeopardy if the nurse were advised in time wherein she was failing. She will either modify her ideas, change her methods, or seek another position more in keeping with her abilities. Therefore, let me urge you as administrators to counsel the nurse with regard to how she is meeting the standard you have set for her. Even a child is graded on his work in school. Is the nurse less to be considered?

The nurse has a right to expect relatively consistent action. Do not formulate plans, or accept her formulations today, if you are going to change them tomorrow. Everyone expects change, and certainly all aspects of medicine are undergoing radical changes today. To these changes all are receptive, in the ever-present struggle for progress. The plea made here is for support of plans and methods either promulgated by the administrator or accepted by him. Nothing is more frustrating to the nurse than to be praised for something today and blamed for essentially the same thing tomorrow. This is the basis of much insecurity among nurses. It leads to unhappiness; yet we know that only happy, alert, interested personnel can give good care to patients. The outward or material needs of nurses have been relatively well met. Salaries, hours of duty, living conditions with few exceptions are good, but how often have we considered the psychological needs of the individual? The writer has seen hospital after hospital where morale was low, with unhappiness manifest on all sides because of inward frustrations. This is probably the greatest single cause of the unrest and consequent inability to stabilize nursing staffs today. Nurses are changing positions far too frequently in this effort to satisfy the need to be a vital integral part of a contributing growing endeavor. It has been universally observed that when the nurse finds a place where the administrator is imbued with a spirit of progress, is dependable, not vacillating, but firm and direct, is willing to delegate authority and adheres

to lines of control, while recognizing the individual by allowing for personnel participation in plans and professional development, she will stay, even when the hospital is undergoing adversities, happy in the knowledge that she is worth while to herself and others. Nurses on the whole are anxious to do a good job. They are willing and eager workers, not easily overcome by external hardships, but a measure of satisfaction must come from the doing or internal stress develops, bogging them down in a mire of unhappiness.

In reviewing the personnel record of nurse upon nurse, the writer has been impressed by the overwhelming numbers of memoranda on failures or shortcomings in proportion to the number submitted in praise of work well done. The army has long recognized the value of achievement awards by citations and medals, but in civilian practice this custom is conspicuous by its absence, particularly with regard to nursing. There is not a physician in the land who is not familiar with the work of Dr. Walter Reed in combating the plagues of malaria and yellow fever, but how many know the name of the nurse who gave her life in that same mission?

One of the greatest among administrators, indeed one of the greatest physicians and men of our time, Dr. Alan Gregg, told me when I began to visit hospitals that I would find them of varying types and standards, but that none would be perfect and none would be utterly bad, that even the worst would have something good if I had the ability to find it, and it would stand me in good stead to look for it and to point it out. He went further and said that greater effort would be made to overcome the defects if, side by side, for each unfavorable criticism, some favorable comment could be made. These were words of profound wisdom and they are equally applicable to the individual whether that person be physician, nurse, or kitchen cook.

Administrators are overburdened and may find it difficult to reach the army of workers and patients who are under their charge, yet there are those who have found ways and means of establishing and maintaining an accessibility to employees and patients with most gratifying results. No administrator can function as a personnel officer with the multiplicity of problems that involves, but if he can occasionally find time to walk into the wards, not on scheduled rounds of inspection, but casually, to see the people at their daily tasks, this evidence of personal interest will pay surprising dividends in the response of nurses, attendants, and others. Not infrequently the administrator is as removed from his employees as Jove on Mt. Olympus; their chief concern being to avoid his wrath or displeasure. Hospitals are large, particularly psychiatric hospitals, and no chief executive can know every employee, but if he occasionally sees them, they soon get to know him, and he becomes a vital factor in their daily lives, changing in concept from *the* superintendent to *our* superintendent.

Last, and greater than all because it is the sum total, the nurse must feel beyond any shadow of doubt that the administrator wants and will accept nothing less than the best possible care for his patients. Many will assume that this is an unquestionable truth that needs no discussion, yet there is abundant evidence to refute the assumption. My successor with this Association, Mrs. Lela Anderson, most dramatically pointed this out when she said—"Some hospitals are blessed with personnel having the vision, imagination, and initiative that enable them to provide a degree of comfort and gracious living for patients despite the meagerness of their funds. In some hospitals we noted the questionable policy of providing food for all personnel employed by the hospitals out of the often meager daily per capita appropriation for patients. To aggravate this deplorable procedure, dining rooms were set up separately for doctors, for nurses, for attendants, for farmers and mechanics. The choicest cuts of meat went to personnel in the upper brackets and the less desirable pieces for the descending levels down the line, so that the poor patients considered themselves lucky when they found an occasional piece of meat in the stew. Contrast with that the hospital—and there were more like it—where all personnel whatever their function including the superintendent had their meals in a beautifully appointed cafeteria. Its democratizing effect was reflected throughout the hospital."

The nurse looks upon her work as more than a job to do. The hospital and all that it stands for, its problems, its struggles, its accomplishments, she identifies with herself. Often it is her home and represents the orbit around which her whole life revolves. She has learned by tours of night duty, overtime, emergency calls, etc., to subjugate her personal plans and desires to the call of duty. This is no sacrifice, but a privilege that she cherishes so long as she carries within her being the knowledge that she is a part, be it ever so small, of an institution that has a high purpose.

In summary, the nurse hopes to work under a medical administrator motivated by high ideals, with a progressive plan for action in which she plays a part. She expects to have responsibility that will be a challenge commensurate with her ability and freedom to operate within her own sphere in the knowledge that she has the support of a fair, direct, and impartial administrator who will judge her upon the merits of her performance, giving honest criticism that does not fail to express the plus as well as minus values in his appraisal of her work. And to function happily and effectively, she must have the knowledge that at all times the patients are the foremost consideration.

In general, young women go into nursing motivated by high ideals and with a genuine desire to serve. Let us strive to keep that light burning brightly!

CEREBRAL PALSY

Medical Considerations and Classification

TEMPLE FAY, M. D.,[1] Philadelphia

Cerebral palsy is a new field of medicine that has emerged in the last 5 years. It has grown so rapidly that the profession has scarcely had time to recognize it and become fully aware of its progress.

"Cerebral palsy" is a term popularized by Phelps and adopted by the lay public to designate types of paralysis, incoordination, tremor, and crippling effects that arise from lesions of the brain, in contradistinction to injuries or disease of the spinal cord, the peripheral nerves, or the extremities themselves.

The condition has long been recognized as spastic diplegia, Little's disease, cerebellar ataxia, or subacute and chronic forms of dystonia or hemiplegia. During infancy and early childhood delay in walking and talking is common. Mental retardation (due to organic brain lesions, congenital or acquired) such as found in cerebral palsy is not to be confused with idiocy and intrinsic mental deficiency.

The recognized causes of cerebral palsy chiefly concern: (1) birth trauma, with subarachnoid hemorrhage or softening; (2) effects of the RH factor; (3) anoxia due to increased intracranial pressure, asphyxia, edema, or hydrocephalus; (4) encephalitis, prenatal virus infections; (5) meningitis; (6) tumors, cysts, hydromas, clots, and abscesses; (7) congenital anomalies, angiomas, aneurysms; (8) defects in blood circulatory or spinal fluid mechanisms, Pacchionian filters, and subarachnoid pathways; (9) systemic or miscellaneous factors that secondarily affect the normal functions of an originally normal brain organ (nephritis, drugs, toxins, etc.).

The term cerebral palsy was chosen by Phelps [2] because of its all-inclusive possibilities. It accepts in classification any dysfunction or alteration of normal motor activity. Patients with cerebral palsy therefore do not necessarily manifest true or complete paralysis of a portion of the body or an extremity. Phelps felt that the selection of the term "palsy" would include the *tremors* such as seen in "shaking palsy." The *rigidities* were also included, where tonal values are changed and altered so that the function of the part has been disturbed, although no true type of motor paralysis exists. Individuals suffering from various types of paralysis or weakness have been referred to in the past as "palsied" persons. In the choice of the term "cerebral palsy," an attempt has been made to get away from the former concepts of "spastic" paralysis, which frequently carried the connotation of cerebral degeneration and feeble-mindedness. The terms "Little's disease" and spastic diplegia have also carried impressions of hopeless states, involving mental changes, which to most clinicians have seemed without therapeutic possibilities.

It is quite obvious, therefore, that this new field will include all those states that may arise from any intracranial pathology (or physiological interruption of continuity) capable of manifesting itself in *dysfunction, altered function*, or lack of function, both sensory and motor. It is also obvious that the term includes not only the problems of infancy and early childhood, but as these problems continue throughout the life span of the brain-injured child they stretch from pediatrics to geriatrics. Perhaps the most important consideration of this field of cerebral palsy is yet to come in dealing with the problems of geriatrics itself, where cerebral vascular accidents, "strokes," and hemiplegias produce types of paralysis and dysfunction to be dealt with therapeutically along the same lines of physical medicine that have already been developed for the younger groups. The important objectives in this field chiefly concern diagnostic screening and re-

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[2] Phelps, Dr. Winthrop Morgan. Personal communication.

habilitation. The lessons learned here, as well as those learned in the management of acute and chronic phases of cerebral trauma, tumors, and organic lesions of the brain arising in later life, have made possible combinations of physical therapy, pattern movements, and therapeutic exercises that are now known to the profession and have proved to be of benefit to the patient. Adults who suffer a cerebral accident or injury now have the benefit of the work already accomplished in the army rehabilitation centers and the classification, education, and vocational training so far established for children and young adults.

From the standpoint of our medical profession, cerebral palsy has offered one of the greatest challenges of the day, and although it is not a "killing" type of disease, it nevertheless, according to Phelps' figures,[3] adds 7 new cases per year in every 100,000 population, or allowing for death of one of the cases, a community incidence of 84/100,000 at age 21.

The number of children and young adults recognized as suffering from cerebral palsy throughout the country is estimated at over 350,000 [4] and with those added to the ranks by brain injury, "strokes" disease and other cause, the estimate has been made at more than 5,000,000.

One of the reasons why this field has been so long neglected and poorly staffed by the medical profession is that its limits are so wide and the problems so varied. During infancy the obstetrician, the pediatrician, and the orthopedic surgeon are primarily concerned with the direct and indirect effects of the brain injury. The organic neurologist, the neurosurgeon and the psychiatrist are vitally concerned with the problem, which pathologically involves their respective fields, and yet there has been little attention given so far to the problem from these groups. Pediatric-neurology, child guidance and child psychology, psychotherapy clinics, with an occasional neuro-orthopedic combination, have arisen to point the way, but so far no coordinated effort nor combined clinic activity has been established. It is at once obvious that, as the individual grows older, the problems concerning sight, hearing, general medical and physical development require special consideration and participation from many specialist groups scattered throughout the profession.

As there has been little attempt to classify this group of patients in the past, common planning or rules for rehabilitation and long-term treatment have not been available. Diverse as the medical problem may be, greater problems exist in the fields of education and training. Here the physical therapist, the psychometrist, the speech therapist, and the occupational therapist, the social worker, and the trained rehabilitationist have attempted to solve the needs for the various ages and for various degrees of handicapping conditions. The educational and rehabilitation groups have been quick to realize the practical difficulties. Accurate medical screening with *diagnostic classification* as well as *planning* and *prognosis* are first essentials in any long-range educational or training effort. The need for some coordinated action between the medical aspects of the problem and the rehabilitation requirements has carried the community forward in a search for help to a point far beyond the medical profession's realization. *Medical* diagnosis, classification, and *properly prescribed* programs of treatment and training are conspicuous by their absence and most urgently needed *now*.

The medical profession has required far too much time to reorient itself, first as to the problem as a whole, and secondly as to how to give to the public the available skill, knowledge, and information needed with the meager resources at hand and how to set up a firmer basis on which to build appropriate measures of accepted therapy for this formerly long-neglected field.

The problem is of primary concern to the medical profession. The rapid growth of lay clinics throughout the country has created a great demand for trained medical personnel, trained physical therapists, and speech and occupational therapists. The communities have come to realize that no such trained personnel exists in adequate degree, and no such demand could possibly be met with the means now available for training small groups under personal direction. An attempt

[3] Phelps, Winthrop M. Recent trends in cerebral palsy. Arch. of Physical Therapy, **23**: 332, June, 1942.

[4] Linck, L. J. Nat'l Soc. for Crip. Children and Adults, Bull., Oct. 30, 1947.

has been made to bring to the younger members of the profession the opportunities of postgraduate medical training in this new and extensive field. The American Academy of Cerebral Palsy [5] was founded to offer a forum for discussion and scientific papers concerned with the problems of cerebral palsy. The founders of this society invited 40 of the interested medical leaders from various specialties throughout the country to participate in the first meeting, held in Baltimore in May 1948. Courses are now being given in certain designated centers for physicians and physical therapists and for those who desire the specialized training. Groups

TABLE 1

CEREBRAL PALSY CLASSIFICATION (PHELPS-FAY)

1. Spastic paralysis		Cerebral
a. Nonspastic paralysis		
b. Atonic type		
2. Athetosis (Types)		Mid-brain
1. Deaf	7. Emotional release	
2. Tension	8. Head, neck, arm	
3. Nontension	9. Shudder type	
4. Hemiplegia	10. Rotary type	
5. Tremor	11. Dystonic type	
6. Cerebellar release	12. Flail type	
3. Tremors and rigidities		Basal ganglia
(a) Parkinsonian types		
(b) Decerebrate types		
4. Ataxia		
(a) Cerebellar		
(b) Kinesthetic		
5. High spinal spastic		Medulla
6. Mixed		Diffuse

of young physicians have been rotated through various recognized clinics in order to give them as many points of view as rapidly as possible.

Although some of the pioneering work has been done in the field of medicine (Crothers, Phelps, Carlson, and Deaver), there still remains much that must be clarified. Certain preliminary steps have been taken to bring about a common ground for discussion and orientation. A temporary classification has been adopted, which is at least the first step in this direction, and seems useful at the moment, but undoubtedly its further amplification will occur promptly and rapidly in the near future, as has been experienced during the recent past (Table 1).

[5] Requires certification in one of the concerned specialties.

One of the first objectives that the medical profession has to face is the problem of *diagnostic screening,* in order that those who are capable of rehabilitation and training can at least enjoy the limited facilities now available. In many instances important training and educational facilities are overburdened by the microcephalic idiot and the other types of idiocy that have no possibility of either eventual rehabilitation or community adjustment in the future. The need for diagnostic screening becomes of extreme importance when it is realized that the present figures offer the cerebral palsied child an opportunity of 2 out of 3 of being educable, and 1 of those 3 a superior and above average type for social and economic adjustment, *provided that proper early training and facility can be afforded.* Institutions are crowded with mistaken diagnoses of "idiocy" for mentally retarded and organically injured brains that have some possible salvage value, and that belong in the field of cerebral palsy. These patients should be carefully screened and removed from the institutions, or appropriate methods of care and instruction provided for their rehabilitation. On the other hand, obvious idiots and hopeless imbeciles still claim the time of skilled teachers and the resources of the community, when institutionalized activities would be far better for all concerned.

The establishment of diagnostic screening centers, adjacent to adequately equipped and staffed hospital groups, has been fully discussed and reported by the Bureau of Child Health in Washington, D. C., in its conference of March, 1947.[6] A 50-bed unit closely associated with an accredited general hospital or medical school was considered a most desirable combination to avoid duplication of the staff requirements. With a specially trained director, such diagnostic screening units should be in a position not only to establish the type and degree of cerebral damage but to plan and recommend the program of care and education that may be possible in the light of the pathology dis-

[6] Proceedings of Conference on Cerebral Palsy, March 26-28, 1947, Federal Security Agency-Social Security Administration, Children's Bureau (1949 Report).

closed. There are several such clinics already established throughout the country.

The fault for this great lack of facility lies primarily with the medical profession itself, in that the problem as a whole has been long ignored or considered as hopeless. Mental retardation, lack of speech, and delay in walking have been considered symbols of hopeless mental involvement rather than educable problems in 2 out of 3 cerebral palsy patients with possibilities for some degree of rehabilitation. The profession has been quick to condemn these handicapped children to institutions that are now overfilled as well as lacking adequate diagnostic facility available throughout the state. Many of these patients have consequently fallen into the hands of improperly trained individuals or institutions without possibilities to properly treat, diagnose, or classify.

With the first steps of classification and diagnostic screening accomplished, correlation of the now existing knowledge from the various fields, the training of younger personnel, the proper supervisional control of the community clinics by the county medical societies (with committees composed of at least the 5 basic specialties concerned, pediatrics, orthopedics, neurology, psychiatry, and neurosurgery) will undoubtedly move the problem forward, as the present organizational programs are brought closer together, and the profession itself receives more enlightenment concerning this new field in medicine.

CLINICAL REPORT ON THE USE OF THE DIMETHYL ETHER OF D-TUBOCURARINE IODIDE IN ELECTROSHOCK THERAPY [1]

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Introduction

In the search for ways to eliminate orthopedic complications, Bennett(1) in 1940 introduced the use of curare in convulsive therapy. At that time only relatively crude extracts of the drug were available. Since Bennett's original publication, more refined forms of curare have been produced. Recently introduced commercially is the dimethyl ether of d-tubocurarine iodide. We have used this product clinically in an attempt to evaluate its characteristics as compared to other forms of curare that have not been without defect in the clinical situation.

The dangers of the various forms of curare became obvious soon after their introduction. Up to 1943, 4 respiratory deaths (2-5) due to the use of curare in shock therapy had been reported in the literature. These represented one-half of the total deaths due to electroshock therapy reported to that time. Since then we are aware of 2 other deaths, one of which has been reported (6). Prolonged periods of apnea following the use of curare in convulsive therapy occur(7, 8) and, even when not fatal, are traumatic and delay the treatment. The use of curare reduces but does not eliminate the incidence of fractures(9, 10). In one series of 232 patients treated with metrazol convulsive therapy(9), the incidence of vertebral body fractures, for example, was 3.9% even when the patients were well curarized. In those cases in which the use of curare is indicated it is evident from our experience and the above reports that the previously available forms have been unsatisfactory. For this reason we have been interested in the clinical evaluation of chemical derivatives of curare.

All curare now used, including the drug under investigation, is originally extracted from chondodendron tomentosum, a plant indigenous to the Brazilian Amazon Basin. Dutcher(11) demonstrated that the alkaloid, d-tubocurarine chloride, is the most potent of the various alkaloids found in the native crude curare extracts from various plants. King(12) in 1935 was the first investigator to methylate d-tubocurarine iodide. Dutcher (11) in 1948 extensively investigated curare derivatives and prepared various methylated derivatives of these alkaloids. He noted the dimethyl ether of d-tubocurarine iodide "to have the highest biological potency of any fraction of curare or their derived organic compounds." Collier *et al.*(13) in 1948 reported that the dimethyl ether of d-tubocurarine iodide was 3.3 times as active as the regular d-tubocurarine chloride and that the dimethyl ether form was, in various species of laboratory animal, several times as long-acting as d-tubocurarine chloride. They concluded that the dimethyl ether iodide form was removed more slowly from the myoneural junction. Swanson *et al.*(14) in 1949 found the dimethyl ether form to be "eight times as potent as the regular d-tubocurarine chloride."

Two reports(15, 16), have to date been published on the clinical use of the dimethyl ether of d-tubocurarine iodide. Both are reports of a series of 100 patients on whom the drug was used in anesthesia. These authors report that it is a satisfactory curariform agent and, further, they observed less respira-

[1] From Department of Neuropsychiatry, Washington University School of Medicine, St. Louis, Mo.

Metubine iodide through courtesy of Eli Lilly Co., Indianapolis, Ind.

The authors wish to express thanks to Dr. Ethel Ronzoni through whose kindness the blood lactic acid determinations were done, and to Drs. E. Gildea, M. Gildea, A. Carr, and R. Bell from whose services the clinical material was supplied.

tory distress than with d-tubocurarine chloride. In their series only 2 cases of respiratory depression could be attributed to the dimethyl ether of d-tubocurarine iodide.

Material and Methods

A total of 41 adult patients were used in this study. All were receiving electroshock treatment for various psychiatric conditions. One hundred and thirty-five administrations of dimethyl ether of d-tubocurarine iodide were given intravenously, both in minimal doses and in head-drop doses. This latter dose was defined as the amount of curare required to induce a muscular weakness that rendered the patient unable to raise his head from the table. All respiratory difficulties were noted. Comparative studies were made on 10 patients each of whom was first subjected to electroshock treatment without any curariform preparations. They were later given electroshock after curarization with d-tubocurarine chloride. Finally, each patient was given electroshock therapy after the injection of dimethyl d-tubocurarine iodide. In each case (in all 3 procedures) the blood lactic acid levels were studied before injection of the drug and again 4 minutes ($\pm$20 seconds) after the electroshock to measure objectively the amount of muscular activity produced by the convulsion. Clinical observations of muscular activity were made on these cases at the time of each convulsion. The remaining 31 patients were studied by clinical observation only, and the advantages of various speeds of injection of the curariform agents were noted.

Results

Our series ran from January 18, 1949 to June 23, 1949, during which time 970 electroshock treatments were given to 160 patients. In 87 of these treatments 33 patients were given intravenous injections of d-tubocurarine chloride to ease the strength of the convulsion. This drug was given in the calculated dose of $\frac{1}{2}$ unit per pound of body weight or in smaller doses if head-drop occurred before the injection was completed.

In the first 10 cases (of the 41 patients who were later to receive the dimethyl ether of d-tubocurarine chloride iodide) observations were made of the strength of reaction to electroshock without the use of any curare preparation. Later, head-drop doses of d-tubocurarine chloride and finally of dimethyl d-tubocurarine iodide were also tried for comparison. Such clinical estimation of relaxation (Table 1) showed that in 6 cases there appeared clinically to be more relaxation with head-drop doses of d-tubocurarine chloride than with dimethyl d-tubocurarine iodide. However, in 8 of the 10 cases studied there was more relaxation when either of the curare preparations was used than when electroshock therapy was given without the drug.

Table 1 also shows a comparison of blood lactic acid determinations in 10 patients who were evaluated without curare, and with head-drop doses of both d-tubocurarine chloride and dimethyl d-tubocurarine iodide. Although fluctuations in the preshock levels of lactic acid render exact comparison questionable, it is apparent in all but one case that the amount of rise in lactic acid following the electro-fit was decreased by the administration of curare. This difference between the curarized and noncurarized state was greater with the d-tubocurarine chloride (31.1 mg./100 cc mean decrease) than with the dimethyl d-tubocurarine iodide (23.2 mg./100 cc mean decrease). These results are shown graphicaly in Fig. 1. It will be noted that either curare preparation, when administered to the point of head-drop, was capable of producing a significant decrease in the usual postconvulsive rise of blood lactic acid.

The consistent, slightly better relaxing powers of d-tubocurarine chloride were, in our experience, obtained at an increased clinical hazard. In 5 patients receiving d-tubocurarine chloride, respiratory difficulties of a moderate to severe degree were encountered. There was moderate to marked laryngospasm in 4, and in 2 of these resuscitation was required for 5 minutes and respirations were labored for an additional 10-minute period. In one patient receiving this drug an emergency intratracheal catheterization for the administration of oxygen was necessary. Although this procedure was accomplished by a trained anaesthetist, the patient later developed mediastinitis and a mediastinal abscess.

In all 41 patients, who received a total of 135 injections of dimethyl d-tubocurarine iodide, we believe that adequate relaxation was obtained when the drug was given in head-drop doses. In this series we noted only minor respiratory difficulties. Eight patients had mild laryngospasm and/or relaxation of pharyngeal musculature postshock resulting in partial obstruction of the airway. Five patients had mild weakness of respiration postshock, while 3 had respiratory difficulties preshock associated with coughing, gagging, and anxiety. Although apprehensive, the latter 3 patients continued to cooperate in their treatments. We did not feel that oxygen or prostigmine was required in any of these instances, as respiration was always spontaneous and of sufficient amplitude to ensure adequate aeration. Difficulties with respiration were variable and on occasion occurred with a smaller dose than the one previously given without difficulty. Occasionally, patients receiving dimethyl d-tubocurarine iodide complained of generalized muscular weakness persisting from 30 minutes to several hours postshock. This was not incapacitating to any of these patients, and we do not feel that this is a contraindication to the use of the drug.

TABLE 1

RELAXATION AS MEASURED BY CLINICAL OBSERVATION AND BY LACTIC ACID LEVELS TAKEN BEFORE AND 4 MINUTES AFTER ELECTROSHOCK THERAPY IN 10 PATIENTS TO WHOM SHOCK WAS ADMINISTERED WITHOUT CURARE AND AFTER D-TUBOCURARINE CHLORIDE AND INTRAVENOUS DIMETHYL D-TUBOCURARINE IODIDE

Patient	Drug given	Cc's necessary for head-drop	Blood lactic acid level (mg./100 cc.) Before	Blood lactic acid level (mg./100 cc.) After	Clinical estimate of relaxation + to ++++	Respiratory difficulty
A	none	...	13.1	99.6	++	
	d-t-c chloride	2.3	9.5	46.5	++++	Moderate
	dimethyl d-t-c iodide	5.3	17.0	55.8	+++	
B	none	...	9.8	84.4	0	
	d-t-c chloride	4.5	6.4	26.2	+	
	dimethyl d-t-c iodide	9	3.8	20.5	+	
C	none	...	7.8	72.0	++	
	d-t-c chloride	3	12.7	37.5	++	
	dimethyl d-t-c iodide	6.5	30.6	77.2	++	
D	none	...	11.8	72.2	+++	
	d-t-c chloride	2.3	17.9	62.4	+	Moderate
	dimethyl d-t-c iodide	5	13.2	51.0	++	
E	none	...	5.8	62.5	0	
	d-t-c chloride	4	6.2	36.2	++++	Severe
	dimethyl d-t-c iodide	7	5.8	44.7	+++	
F	none	...	12.4	68.3	+	
	d-t-c chloride	2	8.5	42.0	++	
	dimethyl d-t-c iodide	5.5	7.4	56.2	++	
G	none	...	13.4	67.3	+	
	d-t-c chloride	3.7	11.1	27.7	++++	
	dimethyl d-t-c iodide	7.5	11.4	41.4	++	
H*	none	...	7.5	60.2	+	
	d-t-c chloride	2.5	12.7	48.2	+++	
	dimethyl d-t-c iodide	5.5	6.6	45.6	+	
I	none	...	6.2	54.4	+	
	d-t-c chloride	3.8	8.1	31.6	++++	Severe
	dimethyl d-t-c iodide	6.5	9.2	36.4	++	
J	none	...	7.4	53.8	+	
	d-t-c chloride	3	8.9	21.8	+++	
	dimethyl d-t-c iodide	4.5	6.6	40.1	++	

* This patient was given 3 gr. sodium amytal preshock.

Inasmuch as we were dealing with a new drug, the initial doses given were first equated to the calculated doses of d-tubocurarine chloride. It was found that such doses of dimethyl d-tubocurarine iodide had almost no observable clinical effect, and it was necessary to give approximately twice the dose of this drug (6.4 cc average dose of dimethyl d-tubocurarine iodide as against

3.1 cc average dose of d-tubocurarine chloride) to produce head-drop. This may at first seem paradoxical in view of the work of Swanson(14) who found dimethyl d-tubocurarine iodide to be considerably more potent in rabbits that were titrated by the head-drop method. However, in the solution supplied to us the dimethyl d-tubocurarine iodide contained only 0.5 mg. per cc, whereas, the d-tubocurarine chloride contained 3.0 mg. per cc. Hence, although less of the dimethyl d-tubocurarine was needed on a mg. for mg. basis, more of the solution was required unit for unit.

Compared to injections of d-tubocurarine chloride given at the usual rate of 1 cc/minute the required larger doses of dimethyl d-tubocurarine iodide given at this same rate created an objectionable prolongation of the time devoted to each patient. The injected doses of the dimethyl preparation necessary to produce relaxation ranged from 3.5 to 11 cc. As we became more familiar with the drug we increased the rate of injection to 2 cc a minute, and later to 3 cc a minute, with no ill effects. Still later, we adopted the method of determining the head-drop dose cautiously on the first trial injection, at the rate of 2 cc a minute, and on subsequent trials administering this empirically determined amount rapidly, intravenously (in 15 to 30 seconds). Head-drop usually occurred between 1 minute and 2 minutes 15 seconds after beginning the injection, at the end of which time the electroshock treatment was administered. This procedure permitted the physician to withdraw the needle from the vein and return to the shock machine before the onset of head-drop. Of 135 treatments with dimethyl d-tubocurarine iodide,

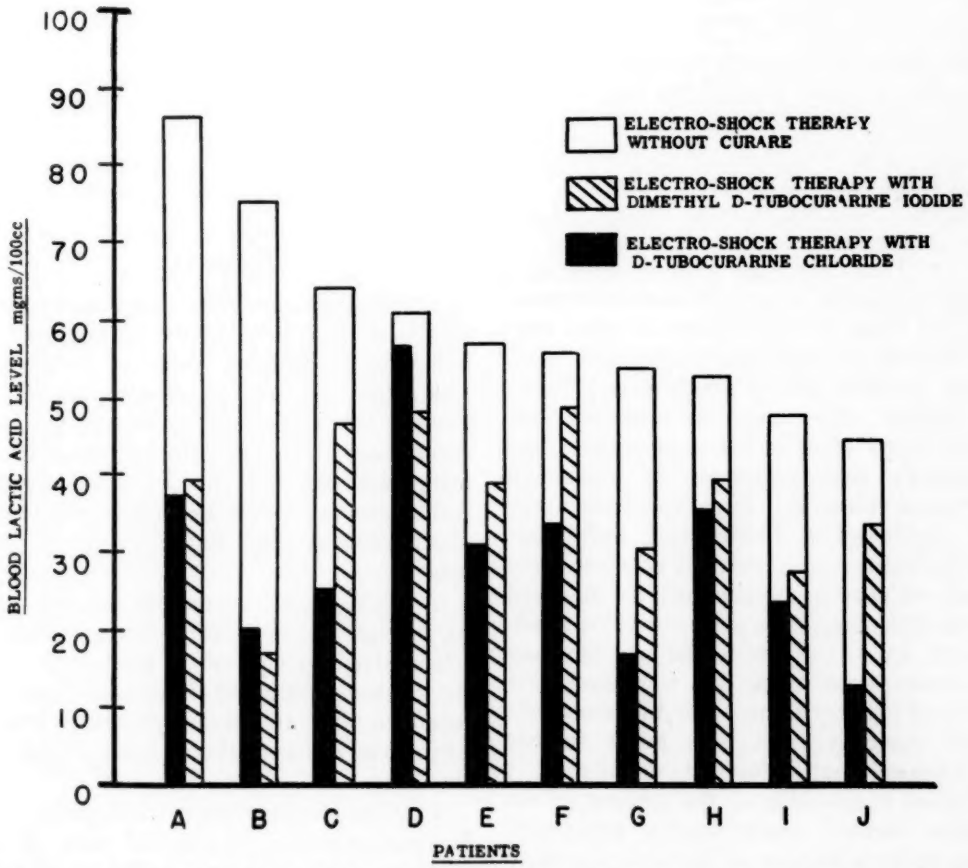

FIG. 1.—Level of blood lactic acid 4 minutes after electroshock therapy in 10 patients with and without curare preparations.

92 treatments were given at a rate of 2 cc per minute; 15 at a rate of 3 cc per minute; and in 28 treatments the total dosage was injected in 15 to 30 seconds. When head-drop was reported electric shock was administered without delay. This latter method of rapid injection has proved for us to be the most efficient way of using dimethyl d-tubocurarine iodide.

Discussion

The theoretical basis as to why one form of curare, if pure, should give less respiratory difficulty than another form is not now evident. The standard commercially prepared form of d-tubocurarine chloride ("Intocostrin" Squibb) is now stated by its maker to be free of other contaminating alkaloids. That curare compounds do have a histamine-like or a central nervous system (18, 19) effect on respiratory and other centers, as well as their main peripheral myoneural junction effect, seems clear. From our clinical observations it appeared that the dimethyl ether iodide form causes less respiratory embarrassment for equivalent degrees of relaxation. However, from available physiological, biochemical, and pharmacological research, there is no clear theoretical evidence to explain such an observed clinical difference. The evidence so far available(11, 13, 14) points to the fact that any differences seem to be due to quantitative biological potency alone. The differences observed clinically must thus await further physiological studies for their elucidation.

Clinical observation of the amount of relaxation seemed untrustworthy apparently owing to such factors as the changing state of restlessness of the patient from treatment to treatment, and to the elapse of 1 to 2 days between shock treatments. We noted discrepancies in judging the amount of relaxation when clinical observations were made on the same patient when a given dose was repeated 2 or 3 times. In one case there was judged to be a stronger convulsion after administration of head-drop doses of curare than when no curare was given, an impression belied by the study of the blood lactic acid.

Although there is debate as to the routine use of curare in all convulsive shock therapy, there are certain instances in which it seems definitely indicated. Such instances include: pregnancy beyond the fifth month, recent abdominal surgery, and recent fractures or orthopedic procedures. During the period of this study one patient receiving electroshock without curare suffered a fractured hip and later died of multiple pulmonary emboli. Hence, in many cases its use will depend upon the judgment of special circumstances and of the patient's general health by the individual physician. When the use of curare is indicated, the dimethyl ether of d-tubocurarine iodide produces satisfactory relaxation with less respiratory difficulty. It seems to us to be superior in this latter respect to d-tubocurarine chloride.

Summary

1. Clinical observations were made during 135 injections of dimethyl d-tubocurarine iodide to 41 patients receiving electroshock treatment. In 10 of these patients the amount of relaxation produced by head-drop doses of d-tubocurarine chloride was compared with that produced by dimethyl d-tubocurarine iodide by methods of clinical observation and by studies of blood lactic acid levels.

2. Although d-tubocurarine chloride seems to produce consistently greater relaxation when given in equivalent head-drop doses, the clinically observed difference is not sufficient to offset the hazard of severe respiratory embarrassment that is encountered with the drug.

3. With administration of dimethyl d-tubocurarine iodide we saw no cases of respiratory embarrassment sufficient to warrant the use of oxygen.

4. It is concluded from this study that dimethyl d-tubocurarine iodide seems to be a safe and useful drug to produce a lessening of the severity of convulsions in electroshock therapy.

BIBLIOGRAPHY

1. Bennett, A. E. Preventing traumatic complications in convulsive shock therapy by curare. J.A.M.A., **114**: 322, 1940.

2. Smith, L. H., et al. Immediate and follow-up results of electroshock therapy. Am. J. Psychiat., **100**: 351, 1943.

3. Charlton, G. E., et al. Curare and metrazol therapy of psychoses; report of a fatal case. Arch. Neurol. and Psychiat., **48**: 267, 1942.

4. Ebaugh, F. G., et al. Fatalities following electric convulsive therapy; report of two cases, with autopsy. Arch. Neurol. and Psychiat., **49**: 107, 1943.

5. Impastato, D. J., et al. Modification of the electrofit. I. Sodium amytal. Am. J. Psychiat., **100**: 358, 1943.

6. Altschule, M. D., and Tillotson, K. J. Untoward reactions to curare consequent to vagal hyperactivity following electroshock convulsions. Arch. Neurol. and Psychiat., **60**: 392, 1948.

7. Jones, G. L., and Pleasants, E. N. Curare modification of therapeutic convulsions. Dis. Nerv. Syst., **4**: 17, 1943.

8. Woolley, L. F., et al. On the use of curare in modifying convulsive shock. J. Nerv. & Ment. Dis., **96**: 680, 1942.

9. Cummins, J. A. Experience with 3,057 administrations of curare to 232 psychotic patients treated with metrazol. Psychiat. Quart., **17**: 655. 1943.

10. Altschule, M. D., and Tillotson, K. J. Modification by curare of circulatory changes during electrically induced convulsions in man. A note on d-tubocurarine. Arch. Neurol. and Psychiat., **59**: 469, 1948.

11. Dutcher, J. D. Curare alkaloids from chondodendron tomentosum Ruiz and Pavon. J. Am. Chem. Soc., **68**: 419, 1946.

12. King, H. Curare alkaloids. Part I. Tubocurarine. J. Chem. Soc., Part 2, p. 1381, 1935.

13. Collier, H. O. J., et al. Pharmacological activities in different rodent species of d-tubocurarine chloride and the dimethyl ether of d-tubocurarine iodide. Nature, **161**: 817, 1948.

14. Swanson, E. E., et al. Dimethyl ether of d-tubocurarine iodide. J. Lab. & Clin. Med., **34**: 516, 1949.

15. Stoelting, V. K., et al. Preliminary study of dimethyl ether of d-tubocurarine iodide. Quart. Bull. Indiana Univ. M. Confer., **10**: 71, 1948.

16. Stoelting, V. K., et al. Dimethyl ether of d-tubocurarine iodide as an adjunct to anesthesia. Proc. Soc. Exper. Biol. & Med., **69**: 565, 1948.

17. Margaria, R., et al. The possible mechanisms of contracting and paying the oxygen debt and the role of lactic acid in muscular contraction. Am. J. Physiol., **106**: 689, 1933.

18. Fegler, J. Action of curare on the respiratory center. J. Physiol., **100**: 417, 1942.

19. Laporte, Y. Utilisation du curare en neuropsychiatrie. Encéphale, **36**: 148, 1948.

AN INSTITUTIONAL PROGRAM FOR COMMITTED SEX DEVIANTS[1]

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As a result of community concern following a series of "sexual crimes," "An act to provide for the treatment of sexual psychopaths in the District of Columbia and for other purposes," was approved June 9, 1948.[2] A "sexual psychopath" was defined as a "person, not insane, who by a course of repeated misconduct in sexual matters has evidenced such lack of power to control his sexual impulses as to be dangerous to other persons because he is likely to attack or otherwise inflict injury, loss, pain, or other evil on the objects of his desire." There is no mandatory provision requiring consideration of any sexual offender for determination as a sexual psychopath. Proceedings are initiated by the United States Attorney and the individual need not be under *any* criminal charge, or he may be charged with a sex offense or any other type of crime. The Act specifically excludes individuals charged with rape or assault with intent to rape. An individual committed to Saint Elizabeths Hospital as a sexual psychopath cannot be released until the superintendent of the hospital "finds that he has sufficiently recovered so as not to be dangerous to other persons." If he is under charges he must be returned to the court where he can then stand trial.

The purpose of this paper is to report briefly some experiences and observations during the period October, 1948, to March 1, 1950, in which we received 24 patients under this law.

Clinically, we have noted that the repetitive pattern of misconduct seems to be consistent in each patient studied and the offenses fall into several typical subgroups:

1. Indecent exposure while intoxicated under the guise of urinating. There are 8 such patients, each with many arrests and sentences.

2. Indecent exposure while sober. There are 4 of these; one showed limited intelligence and 3 are classical hysterical exhibitionists, one of whom performed indecent acts with children.

3. Various indecent acts with children. There are 7 cases varying from an old man's enticement of girls for sex play to a 20-year-old's immature, slightly coercive homosexual behavior with younger boys.

There are 5 others of disparate nature, including 2 non-coercive homosexuals and 1 aggressive sodomist.

Only a very small percentage of individuals charged with sexual offenses during this period were referred for determination of sexual psychopathy. In 1948 and 1949 there were a total of 636 sex offenses reported. Of these, only about 20 were committed as sexual psychopaths. In a recent radio broadcast the United States Attorney for the District of Columbia stated, "The vast majority of the cases have been handled as strictly criminal prosecutions and, if the man is convicted, the court sentences him to jail. We feel that if it's handled gradually and the extreme cases are referred to the sex psychopath portion of the Act, that will give us some time to develop the best possible solution"(1).

It appears then that our patients are not truly representative of the sexual offenders in the community. Keeping these considerations in mind we want to discuss certain aspects of the problem based on the group that we have received.

Representative Cases

A few representative cases are cited by way of illustration:

Case A.—A 25-year-old, married, colored musician with numerous arrests since adolescence for larceny and 18 arrests for exhibitionism and peep-

[1] Read at the 106th annual meeting of The American Psychiatric Association, Detroit, Mich., May 1-5, 1950.
From St. Elizabeths Hospital.

[2] Public Law 615, 80th Congress, 2d Session.

ing. He has used alcohol, cocaine, and marijuana since age 12. He came from a broken home and was institutionalized many times before the age of 12. He has never worked more than a month or so, has been socially irresponsible, and he blames society for all his troubles. His marital adjustment has been very poor. In the hospital he has been evasive and circumstantial, and he has claimed to have solved all his problems, although he protests about being in "double jeopardy" since his commitment as a sexual psychopath occurred while he was awaiting sentence for robbery. He is immature and egocentric but has made a good hospital adjustment.

CASE B.—A 70-year-old, white widower who performed fellatio while he was drunk with young boys to whom he gave gifts. His father died when he was 4 and he was overattached to his mother. Until his wife died 3 years ago he made a good social and sexual adjustment except for one arrest in 1933 on suspicion of sodomy. He was impotent before his wife's death and he began to drink heavily and be despairing afterwards. He shows minimal organic signs with transient sensorial clouding. His ward adjustment is exemplary and he makes some requests for discharge, stating he will never misbehave again.

CASE C.—A 29-year-old, single, white truck driver with 5 sentences for indecent exposure since 1942. Each offense occurred while he was drunk and he was urinating on the street. His family is heavily alcoholic; he is the oldest of 5 siblings and he had enuresis until age 8. He has always been shy and distant and he shows marked verbal ineptitude. Heterosexual behavior has been stereotyped and sterile. He has been heavily alcoholic since the death of his father 11 years ago and he has been arrested for concealed weapons and 3 other minor charges since then along with the indecent exposures. He has made a quiet hospital adjustment, but it has not been possible to arouse him to treatment.

CASE D.—A 34-year-old, white, three-times-divorced accountant. He was orphaned at one year, had poor foster home placements until 12 and then made a model adjustment in an orphanage until age 18. His work record is fairly good but his social contacts have been superficial. He has feelings of inadequacy, which exacerbated after failures in marriages or jobs. At these times his preoccupation with his unworthiness has resulted in compulsive, seemingly nonlustful touching of young girls in situations where he would be apprehended. Since hospitalization he has been a superficially "good" patient but his self-punishing operations have been very conspicuous. His jobs, therapy, and friendships have all evolved into failures. He has requested castration and lobotomy in similar masochistic moves.

THE SYNDROME OF "INDECENT EXPOSURE"

Observation of our group of exhibitionists has revealed certain clinical characteristics. In contrast to other offenders, the exposures are frequent and repetitious. As individuals they have shown a limited and stereotyped heterosexual performance with rigid standards of "normality." Common is psychological dependence on medicines with tendencies to go on sprees of analgesics or alcohol. In the history prolonged enuresis is frequently noted and the common explanation for the act of indecent exposure is urinary urgency. They have been superficial and transient in their social relationships. Exposure frequently followed feelings of defiance and disappointment. These people are conspicuously nonverbal in their integrations and on psychological tests.

THE INSTITUTIONAL PROGRAM

We approached the problem of therapy with the conception that the sexual performance of an individual is but one manifestation of his total personality structure. In our experience the sexual deviation precipitates commitment and is simply the "tail that wags the dog." Our cases include such nonpsychotic clinical syndromes as mental defectives, organics, compulsive neurotics, ambulatory preschizophrenics, hysterics, and possibly a few "psychopaths."

Individuals committed under this law receive the same type of intensive psychiatric workup as is accorded to all patients in the maximum security division of Saint Elizabeths Hospital. The patients are seen on admission by one of the senior physicians and, after a detailed admission interview, are initially evaluated for therapeutic assignment.

At the time this Act went into operation we had already had for some years a fairly complete program of individual, group, and milieu psychotherapy, which has been described in preliminary papers(2). Fuller aspects of this program are to be published in the near future(3).

Briefly, the program provides for a full schedule of activities occupying the entire day. There are therapeutic group meetings and administrative group meetings, art, drama, and special projects groups, and occupational therapy workshops. There are recreational activities, such as group athletics (baseball, basketball, boxing, volley ball,

ping pong), movies, television, library, and music practice. The patients' newspaper, the Howard Hall Journal, has received much favorable comment.

Within a few months after admission each patient is brought to a conference where his case is fully discussed and evaluated, and patients who appear to be reasonable risks are transferred from maximum to minimum security (thus far, 6 cases). In this latter ward they continue with group therapy and individual therapy in selected cases. The patients admitted under this law are also assigned to a small "special group" because of their expressed feeling that they can discuss their sexual difficulties more freely with those whose problems are similar. In minimum security they have many opportunities to attend the hospital amusements, including dances and parties, and are given some kind of occupational assignment upon the grounds from which they come and go without supervision. This permits them to attend the psychodrama sessions held in another building and also offers them an opportunity to test developing awareness of their problems through contact with others. Throughout the program the over-all therapeutic atmosphere continually exerts a uniform, nonspecific pressure in the direction of health.

The structuring of a therapeutic milieu deserves considerably more discussion than would be possible in this limited account. An important facet of the milieu therapy is the frequent meeting of all members of the staff to discuss and work through any reaction-formations they may have and to assist in the selection of specific doctor-patient pairs for therapy. In this connection, the discomforts of attendants in dealing with this group of patients is a source of continuing investigation and occasion for some discussion between physicians and attendants. Preliminary projects include a kind of group therapy seminar for the attendants.

Our emphasis on a purely psychological approach to therapy is based in part upon a review of the literature that has thus far disclosed no rationale for any specific physical therapy such as castration, hormonal injections, shock, insulin, or lobotomy (4).

General Characteristics of the Group

Although the group is small and variegated and our period of observation brief, certain characteristics seem apparent in these people in their group functioning.

They are passively dependent, covertly and passively hostile characters. There is frequently exhibited an attitude of "injured innocence." Many of them are manipulative, rigid, and have a paradoxical pride in their status as sex deviants. This latter aspect may derive in part from their distortion of the hospital's interest.

By far the greater number are not currently amenable to a type of dynamic and insightful intensive psychotherapy. They are superficial and telegraphic in their communications, show little capacity for introspective or psychological thinking, and give only lip service to the attempts of the therapist to mobilize interest in surmounting their difficulties in living. The most frequent presentation is, "Well, if you say there is something wrong with me, suppose *you* do something about it." The idea of a collaborative effort is quite difficult to establish, although inexperienced therapists might be led astray by the ingratiating and agreeable manner of the manipulative members of the group. There is an unusually high degree of recourse to minimizing and defensive processes such as rationalization and projection. These individuals show a rather poor prognosis for psychotherapy because they almost invariably are unable to assume responsibility for their own treatment and continue indefinitely in a state of either strong latent negative resistance or of passive hostile dependence. There tends to be a marked absence of any "neurotic suffering" as a stimulus toward work in psychotherapy. Those who deny their dependency draw heavily on repressive mechanisms, which further defeats the attempts of the psychotherapist. Notwithstanding, a small proportion (about 6) in our group have indicated some amenability to psychotherapy and are making slight progress.

The Problems

The problem of how to deal with the sexual psychopath has come into considerable

prominence in recent years. Tappan reports that habitual sex offenders have been the object of special laws in at least 13 jurisdictions in recent legisative sessions(5).

A number of clinical and administrative problems are created by this group. The law defines a sexual psychopath, requires commitment to Saint Elizabeths Hospital upon judicial determination, and provides that he is not to be released until certified as "sufficiently recovered so as not to be dangerous." Clinical questions as to the precise psychiatric definition of the term "sexual psychopath" are not within the scope of this paper. The type of therapy most appropriate to achieve the goal set by the law must be determined for the actual patients committed by the law. The decision of the court for commitment as a sexual psychopath is actually a "diagnosis" which is not reviewable by the psychiatrist responsible for the subsequent treatment.

The courts are understandably concerned with the preservation of public peace and the segregation of individuals who are considered dangerous to others. The psychiatrist as a physician is primarily interested in the treatment and amelioration of individual human distress. While these two objectives are not necessarily incompatible, it is our experience that they frequently are divergent and occasionally at cross purposes. If the considerations as to civic responsibility are rather heavily weighted in favor of detention and segregation, then the penologist or correction officer is a more efficient custodian than the psychiatrist.

Given the group of people described, what constitutes the most appropriate therapeutic approach? We believe that insufficient information is available to establish solely the efficacy of any particular psychotherapeutic procedure. It is our general opinion, however, that only a dynamic and insightful type of intensive psychotherapy offers any prospect of modification of personality structure with some insurance against repetition of offense upon discharge of the patient. We recognize, however, that this is impossible in a general application because of (a) the prohibitive cost, (b) the lack of fully qualified personnel for the number of patients who are in need of such treatment, and (c) the type of patients being sent to us thus far. Lacking this, then, an alternate type of program expressing dynamically oriented attitudes toward the problem of psychotherapy seems essential.

We have described thus far an institutional program utilizing an already well-established program of group and individual psychotherapy. We have modified this program in some aspects to fit the special needs of this group but find that there are certain limitations to such modifications when operating within the facilities of an institution primarily designed for the care of psychotic individuals.

"Sufficiently Recovered"

The question of what constitutes cure again brings up the problem of whether cure is to be established only on the basis of a dynamic and insightful awareness plus actual personality change or whether cure can occur without "insight." It is recognized that a great many symptomatic improvements occur in such conditions as schizophrenia without the application of anything other than hospital atmosphere. Such cures are always fragile and not necessarily a protection against further difficulties.

Thus far we have not established any dependable set of criteria to use in predicting the future course of conduct or misconduct in our patients. It appears likely that a problem will eventually be occasioned by the collection of a residual group of individuals who we believe do not form particularly promising therapeutic risks and for whom little more than a high type of custodial care can be offered. In this connection there is a seeming disparity in that individuals who make "good hospital patients" are not infrequently those who form rather poor therapeutic risks. They may fit well into the standard hospital program and quickly assume a fixed, passive dependence. Although such individuals may adjust well in the hospital, this adjustment is no promonitor as to whether they could refrain from reestablishing their socially unwanted activities upon release. In other psychiatric conditions the psychiatrist finds himself, through long experience, with a much better defined set of criteria for predicting such things as suicide, combative be-

havior, and symptomatic exacerbation, and for evaluating recovery.

Conclusions

1. The group of patients reported is not statistically representative of the varieties of sexual offenders in the community.

2. It appears unlikely that very many of our group are sufficiently amenable to therapy so as to be "recovered" as required by law. In this connection, while we believe that their illnesses are psychodynamically determined, it is doubtful whether present techniques are equal to the task of cure.

3. Under the present law, the majority of the cases received have been exhibitionists. Certain characteristics of this group have been described. It is questionable whether the exhibitionist is a sexual criminal of sufficient menace to justify indefinite commitment and whether the incidence of heinous sexual crimes will be reduced by his confinement. In our experience thus far, the exhibitionist is in general a relatively poor risk for intensive therapy and he is likely to remain indefinitely since he cannot be certified as "recovered" as required by the law.

4. Considerably more research is needed into all phases of this problem, particularly with respect to the elaboration of criteria for prediction of behavior in these individuals before and after various therapies.

BIBLIOGRAPHY

1. Radio Broadcast, Station WTOP (CBS), April 11, 1950.

2. Abrahams, Joseph. Preliminary report of an experience in the group therapy of schizophrenics. Am. J. Psychiat., **104**: 10, April 1948.

———. Group psychotherapy, remarks on its basis and application. M. Ann. District of Columbia, **16**: 11, Nov. 1947.

3. Abrahams, Joseph, and Cruvant, Bernard A. Manual of Group Therapy. In preparation.

Tartaglino, Francis J., and Cruvant, Bernard A. Forestalling chronicity in the hospitalized patient. Read before Med. Soc. St. Elizabeths Hosp., April 1949.

4. Preliminary Report of the Subcommittee on Sex Crimes. Calif. legis. assembly. March 8, 1950.

Report of the New Jersey Commission for the Study of the Habitual Sex Offender. February, 1950.

Selling, Lowell S. Report of regular meeting Jan. 11, 1940, Mich. Soc. Neurol. & Psychiat. Arch. Neurol. & Psychiat., **43**: 1276, 1940.

Silverman, Daniel. Treatment of exhibitionism. Bull. Menninger Clin., **5**: 85, May 1941.

Wile, Ira S. Sex offenders and sex offenses: classification and treatment. J. Crim. Psychopath., **3**: 11, July 1941.

East, Norwood. Society and the Criminal. London, His Majesty's Stationery Office, 1949. Chap. 7: Treatment of Sexual Offenders.

Bowman, Karl M. Challenge of the sex offenders: Psychiatric aspects of the problem. Ment. Hyg., **22**: 10, Jan. 1938.

Golla, F. L., and Hodge, R. Sessions. Hormone treatment of the sexual offenders. Lancet, **1**: 1006, June 11, 1949.

Rubinstein, R. S., et al. The treatment of morbid sex craving with the aid of testosterone propionate. Am. J. Psychiat., **97**: 703, Nov. 1940.

Report of the Joint Com. on Psychiatry and the Law, appointed by British Med. Assn. The criminal law and sex offenders. Brit. M. J., **1**: 135, Supplement, March 12, 1949.

5. Tappan, Paul W. The sexual psychopath. A civic-social responsibility. J. Social Hyg., Nov. 1949.

GROUP THERAPY IN SEXUAL MALADJUSTMENT[1]

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Group psychotherapy has been employed in the treatment of various types of mental disorders during the last two decades. It gained increasing acceptance during the war period in dealing with war neuroses, both as a measure of expediency and because of its specific value as a therapeutic technique.

In the course of our experiences with problems of marital maladjustments it appeared to us that group therapy might also be usefully applied to marriage counseling. Heretofore, marriage counseling has always been considered to require strict individualization. Problems of marital maladjustments had been assumed to be so personal and intimate that they could be treated adequately only in consultation with the individual person or the individual couple in question. In reviewing our histories, however, we were increasingly impressed with the fact that the problems presented by couples coming for advice fell into several specific categories, and that group counseling might be a suitable form of therapy in certain selected cases. We decided, accordingly, to initiate an experiment in group therapy in this field.

The experiment was begun in 1945 at the Margaret Sanger Research Bureau. This Bureau is the oldest and largest planned parenthood center in the United States. From 5,000-6,000 new patients come there annually for advice on contraception, for the treatment of infertility, and for other services. Several questions on our regular history form relate to marital and sexual adjustments, and potential sources of marital difficulties are thus often revealed at the first interview. Some women, furthermore, come for contraceptive advice specifically in the expectation that information on family planning may aid their sexual adjustment in marriage. We thus had an ample source of patients from whom to select cases for group therapy.

People bring to the marriage counselor a variety of problems—economic difficulties, in-law troubles, personality conflicts, sexual incompatibilities, parent-child tensions. Largely because of the nature of the Bureau's services, we selected for our first experimental group cases with sexual maladjustments. In the majority of instances the chief complaint was difficulty or inability to achieve an orgasm during the sexual relation. Some of the women stated that they could achieve an orgasm through external sex play but not during the act of intercourse, while others said that they could not obtain an orgasm under any circumstances. A few of the women said that they had little or no sex desire, and that they merely submitted to their husbands as a matter of duty or expediency.

In the initial interview, most of the women ascribed the difficulty to their own deficiency, but some laid the blame for their sexual failure on the ignorance, indifference, or inadequacies of the husband. The chief complaints mentioned by the women indicate the range of problems. These were:

Lack of sex desire.
Difficulty in becoming aroused.
Arousal only after much pre-coital play.
Lack of any sensation in coitus.
Orgasm only from external play, but not during coitus.
Fear of intercourse.
Fear of pregnancy.
Infrequency of sex relations.
Painful intercourse.
Orgasm achieved only in certain positions.
Husband's anxiety over wife's lack of response.
Husband's objection to wife's need of precoital play.
Husband's loss of sexual interest because of wife's frigidity or slowness of response.

This list presents merely the primary complaints. During the discussions, many additional problem areas touching upon basic questions of personality and compatibility in marriage were constantly revealed.

In our marriage counseling work we have taken the basic assumption that most women have sex desires and sex needs. The degree

[1] From the Marriage Counseling Service of The Margaret Sanger Research Bureau, New York, N. Y.

of desire and the frequency with which it manifests itself varies with the physical, emotional, social, and cultural development of the individual, but practically all women have sexual desires, and are capable of a degree of satisfaction that could culminate in an orgasm. If the desire or the ability to achieve an orgasm is lacking, we assume it to be due either to physical or physiological incapacities, to deep-seated inhibitions and conflicts—emotional blocks which prevent a complete response, to inadequacies in the technique of sex relations, or to the influences of the personality traits of the couple.

In organizing our program of group therapy these several possibilities were taken into consideration. All the women admitted to the group had been referred to us from the contraceptive service where they had already been given a thorough pelvic examination. Data were therefore available to exclude the possibility of any physical abnormality or any local inflammatory condition that might interfere with adequate response. Many women, and for that matter, many men believe that their sexual difficulties are the result of some organic disturbance, or of some physical abnormality. The reassurance that a patient obtains, therefore, from negative findings after a thorough physical examination is in itself of great value as a psychotherapeutic measure.

The idea that a disturbance is psychological rather than organic in origin may, on the other hand, be a source of considerable distress to patients, for in their minds this is associated with a reflection upon their mental health. An attempt was therefore made at the initial interview to allay such anxiety. Psychological causes underlying cases of sexual maladjustments were explained to the woman, or to the couple if the husband was present, and the need for a more thorough exploration pointed out. Usually the opportunity for further help was readily accepted. This initial interview was also used to discover in greater detail the nature of the particular problem, and whether the couple was suitable for group therapy or the group acceptable to them. Those who did not fit into the group or for whom the group idea was unacceptable were either seen individually or referred elsewhere.

To avoid possible conflicting attitudes, an attempt was made at the beginning to choose couples of a similar age and with fairly similar educational and social backgrounds. Most of them were in their twenties, married for a year or less, with a high school or partial college education, and belonging to the semi-skilled and skilled worker groups. As time went on, however, we included couples with different marital and cultural backgrounds, choosing them primarily on the basis of their common complaint.

PROCEDURE

Since we had no precedent we had to develop our own methodology as we went along. We decided at the outset that it was essential to have discussions both with the wives and with the husbands, but that it would be desirable to see them in separate groups. As the problems were generally presented by the wives, the first 3 sessions of 2 hours each were devoted to them, and later we met separately with the husbands.

This report is based on a series of sessions with 8 such separate groups, comprising a total of 72 women and 42 men. The individual groups ranged from 5 to 13 members. The numbers were deliberately varied in order to determine the optimum for a group. We now feel that from 6 to 8 is the number most suitable.

About 6 months after each group's initial session, the members were asked to return for a follow-up meeting in order to evaluate the results of treatment.

To provide a clearer picture of the conduct of these sessions, they will be described in sequence. Since we have varied their character from time to time, the description actually presents a composite picture of several groups.

First Session.—The members of the group gather in the evening, at about 8 o'clock, in the library of the Bureau, a pleasantly furnished, comfortable room, and are seated informally around the room. The doctors sit at a table facing the group, and a secretary unobtrusively takes notes on the side. One of the doctors opens the discussion by out-

lining the aims of the sessions and the desire to provide an opportunity for a free exchange of experiences, opinions, and information. It is pointed out that all members in the group are known to have difficulties in their sexual adjustments, and that the meeting is an attempt to clarify the underlying causes and to see what measures can be taken to correct them. The women are introduced to each other by their first names, and each one is asked in turn to give a summary of her marital history, including information about the number of years married, the number of children, and the nature of her particular problem.

This is followed by a discussion of some of the basic factors involved in the sexual relation. Brief mention is made at this time of the frequent lack of preparation on the part of women for the sexual side of marriage, of the differences in attitude between men and women thereto, of the degree and frequency of spontaneous desire in women, the importance of adequate arousal, and the nature of the orgasm, whether achieved through stimulation of the clitoris or of the vagina. It is pointed out that sexual difficulties may result from either physical or psychological causes, but that adequate coital techniques often help to overcome some of the psychological barriers to complete response.

A conscious effort is made to present this preliminary outline in an informal, conversational manner with occasional questions directed to one or another member of the group in order to bring them into a discussion. Comments and questions are encouraged, and the therapist frequently asks other members of the group to reply to some of the questions on the basis of their own experience and attitude.

By the end of this preliminary discussion, which lasts for some fifteen minutes, the group is usually quite at ease and ready to participate in the conversations that follow. Often the content and character of this discussion provide immediate clarification and understanding. Here, for example, are some of the remarks made at this point as recorded in our notes:

Mrs. A.: I have already learned something I did not know. Now I understand why I am here. I have been married fifteen months, and have not gotten any satisfaction yet. I am aroused when my husband plays with me, but as soon as he enters I lose all feeling. I lose it and I don't get it back again, and I get disgusted. Often I start crying. Now I see some of the reasons for our trouble.

Mrs. B.: I think that my problem is tied up with the fact that I was brought up in complete ignorance. I was married all of a sudden and I was supposed to know everything, and I did not know anything. I blamed myself all the time. The whole atmosphere was so bad that I could not talk to anybody about it. For the first time now, it is getting clear to me what the relationship is.

The remaining part of the first session is taken up with a frank discussion of the women's own experiences and reactions in their marriage. Personal experiences are disclosed very freely, and most of the women speak without hesitation and in considerable detail about their problems. Continually the doctor attempts to direct the discussion along channels that will promote better understanding and a clearer insight into the nature of their difficulties. Facts in the patients' sex histories are often brought to the surface spontaneously and at times with a great deal of emotion. At one point, for example, one of the women suddenly stated with much anxiety, "This has nothing to do with what you are talking about, but when I was a young girl I used to masturbate." And she burst into sobs. The reaction of the other members of the group was extremely reassuring, as they, in turn, told of their own sex experiences in childhood.

Second Session.—At the meeting a week later the women are very friendly and verbal in their greetings. The doctor reviews briefly the topics of the first meeting, and asks for a progress report of any developments during the week. Some of the women state that there has been no change, or that they had had no chance to find out, and others report a definite improvement in attitude. "I derived much comfort," said one woman, "from the fact that other girls had the same problems. Many things I thought were abnormal or out of the ordinary I find to be quite natural and ordinary. It freed me from many wrong ideas and feeling of guilt. I feel much more at ease now with my husband." Another stated: "One thing I learned —that there are others in the same boat,

and that their part of the boat may be sinking even faster than ours. If they can stay up, so will we." One may report that she had a completely satisfactory relation on one or more occasions during the week. She is immediately beset by the others with questions on how the change was brought about, the nature of the reaction, and so on.

At the beginning of the second session of one group, one woman stated:

I think I realized at the discussion last week that I had not been instructing him properly in the preliminary play. This time I did. He cooperated, and I had an orgasm—the first time in my 3 years of marriage.

When asked by another what her sensation was, she answered:

It was very thrilling. It was short but very satisfying. I was enjoying myself so thoroughly, I did not bother to feel. I could not control my cries. The first time it took perhaps more than 15 minutes before it happened; the second time, only 5 minutes.

The session then continues with a discussion of the other factors that influence the sex adjustment of husband and wife. The theme centers around the questions of mutual affection, love, and personality adjustments. The development of the feeling of love from infancy to maturity, and the elements of a mature love-relationship are briefly outlined. This is followed by a discussion of personality traits, the factors in their development, and the influence of childhood experiences and home environment on the formation of character and habit patterns. The degree to which these traits and attitudes influence sex response and sex adjustment are then pointed out.

The members of the group enter this discussion very freely, and many relate their own love experiences and the stories of their courtships and marriages. Striking differences in attitudes and in feelings toward their husbands are noted. In some cases there appears to be a very deep mutual affection, but in many there is evidence of lack of any strong feelings. One woman said:

What I like about marriage is that the feeling grows. At one time we thought we were in love, but now we know we really are. We have companionship, honesty between each other—everything on a 50-50 basis. He'll chip in and help me in everything. That doesn't exist in many marriages, so I feel I'm lucky to have it.

An entirely different attitude is expressed by another member of the group:

I don't know much about it. I always ask "What is love?" We went through high school together, and I went out with a great many boys, but I did not fall in love, and I came back to him. He was after me 4 years, and I finally decided, since I had not anyone else, that I did love him, and so we were married. I am very bossy, nervous and ambitious; he is the opposite. To him life is just a party. He wants lots of friends and wants to go out places. Now he is going to college, and I do all his homework. I force him to study. He wants to put it off. To me sex is not too important. I feel other things are more important. For example, the term paper he should be writing. I don't show feelings easily.

Another, in discussing her husband's courtship and her attitude toward him, stated:

Mentally I am much older than my husband. I feel I know much more about business than he does. Sometimes, I feel that he knows I am the boss. In the business I was more than a woman and carried the responsibilities of a man. I am afraid that maybe he also lets me be a man instead of a woman in sexual ways. Do I have to tell him everything? I like to boss, but I don't want to hurt his feelings. He says he owes everything to me, and I don't want him to say that. When we have sex relations I have an urge to say, "Stupid, come on!"

This is followed by a statement from another woman:

Love for me has never been a definite feeling. The first years there was physical attraction, but not love in the sense I always thought it was. But now my love is much more intense for the child than for the husband. My mother was cold to me, and our family life was reserved, and I have never shown much love. I have it inside of me, but I am not able to break through. The only one I can show unrestrained feeling toward is the child.

Such statements give rise to many comments about the relation of love and affection to sexual response. The importance of the security of a love relationship, of mutual tenderness and respect is stressed by many members in the group. Many complain of the lack of demonstrativeness on the part of their husbands, their failure to show affection in their behavior. This point comes up again and again. For example:

Mrs. C.: Our love seemed to be much more exciting the first years before the birth of the child. Now there is only a placid feeling. He doesn't show the attentions he previously did. He never comes over and kisses me. I would rather go without eating and have gifts, but my husband is too prac-

tical. It is not the gift I want, but because it would show his affection. But he doesn't see it that way. If I want it, he says I can go out and buy it myself. He demonstrates his affection for his mother; why can't he for me?

Mrs. D.: There are more important acts than the sex act—a pat on the back, a caress would mean more to me than sex. But he doesn't do it anymore. Some men are affectionate and demonstrative and use words of endearment freely, but my husband doesn't. . . . He finds it difficult or maybe not important enough to express love. He can't say "I love you." I am constantly asking, "Do you love me?"

Mrs. E.: The spoken word means so much. They don't know it. I have the same problem. He means it, but is not the type to share words with me.

Third Session.—By this time the relationship between the women has reached a comradely stage, and there is no feeling of restraint. There is also a noticeable interest in improved personal appearance—a more attractive attire, a nicer hairdo, a generally brighter look. Women who previously showed marked tension and anxiety now appear at ease and relaxed.

The material that had emerged during the two previous sessions is briefly reviewed and evaluated. The chief topic of the evening is the effect of early education or lack of it, upbringing, training, conditionings, and traumatic childhood experiences on sexual behavior and response in later life. The doctor discusses the effects of home environment, parental attitudes and training on the emotional and personality development of the child, and the consequences in later adjustments in life. The feeling of guilt, fears, and resentment that may result from lack of preparation or from distorted information are also mentioned. This brings out much revealing material concerning early experiences, the beginnings of sex awareness, traumatic episodes during childhood, and leads to considerable analysis and resulting insight.

Here are a few excerpts from the discussions during this session:

Mrs. F.: One thing about my family—they would make smutty jokes and laugh. Slowly I began to understand things. I felt my father made sex filthy, even though it was discussed openly.

Mrs. H.: I have young American parents, but my sex training was not very good. I had a friend 6 years older who taught me everything I knew. We were walking along a street and saw a condom. She called my attention to it and told me what it was. Later on, I found one in my father's bureau drawer. I could not conceive of my father and mother having relations. I did not speak to father for a long time.

Mrs. I.: I did not know about menstruation before it came. When it did, I went to sleep afraid I was not going to live. Mother explained it to me the next morning. I knew nothing of marriage, and I have always been annoyed to have to submit to intercourse. These discussions have helped a great deal. They made me see things clearer. Now, I don't run away from his touching me. At first I did not like it, but now I even find it pleasurable.

Early sex experiences and aggressions by older individuals are also recalled. Such episodes seemingly occur surprisingly often in a metropolitan area. Most of the women recall childhood incidents of encountering deliberate male exposure while on the street, in hallways, in the subway, or of sex manipulation by an older member of the family or by a stranger. These experiences do not always have a traumatic effect, but in some instances a feeling of anxiety and guilt is carried over into adult life and influences sexual reactions. This is especially true when the incident was accompanied by pleasurable sensations.

The following few stories are illustrative of the type of experiences frequently encountered:

Mrs. M.: Maybe I'm the way I am because of something that happened to me when I was a child. I had a horrible experience. When I was five years old a man molested me. I didn't realize what happened until later. I had a terrible guilt feeling. I used to think I would die. It happened several times after that with other men. When I grew up I hated boys!

Mrs. N.: When I was eight I once visited a girl friend. Her grandfather came in. He stood in the back of my chair and played with me. I wanted to get away, but I didn't cry out. I thought about it continually and still think of it today when I look at an old man. I was embarrassed and ashamed.

Mrs. O.: There was a man in our neighborhood who had wonderful rabbits. All the children would come to see them. I was then about nine years old. One day I was leaning over the cage watching the rabbits. The man stood behind me and touched me through my clothes. It was very pleasurable. I used to come back and he continued to touch me. Later the family found out and they were going to send him to jail.

Some of these stories of early sexual experiences are told with a great deal of anxiety and much emotion. "It is the first time I ever told anyone about it," one

woman said amidst tears. The group is sympathetic. The revelation that others have had similar experiences is a source of great relief and reassurance. The attitude during these discussions is serious and understanding and usually unembarrassed. There is a strong sense of rapport among the members of the group, and between them and the doctor. There is a desire to be helpful and to be helped.

The third is the last session with the wives, and toward the end the women are asked to state what particular points of information or attitudes they would like brought to the attention of their husbands who are to come the following week. Here are some of their statements:

Tell them that a woman likes to have her husband express his feelings of love. She wants to hear him say so and feel his affection.

Can you get over to the men that intercourse cannot be the ideal the books make it out to be?

Please don't tell my husband that I don't get an orgasm. I only told him that there is some problem and I did not feel the way I should. After all, you can't tell your husband everything.

Tell the men that a woman can be satisfied even though she does not reach an orgasm.

Session with Husbands.—At this meeting sex anatomy and physiology are briefly reviewed with the aid of anatomical charts and pelvic mannikins. The various factors that may contribute to lack of complete response on the part of the woman, the differences in attitudes toward sex activity between men and women, and the importance of adequate sex techniques are discussed. Many of the facts presented appear to be quite new to some members in the group. Some men find that in spite of their presumed sophistication, and even varied experiences, they lack fundamental information about structure and function and attitudes.

The remarks and suggestions expressed by the wives are often utilized as a starting point for discussion. Many different viewpoints are expressed on the question of being more demonstrative and affectionate. Some of the men state that they find verbal expressions of love difficult and they ascribe this to their home experiences. Some of the statements as they appear in our records are:

Mr. Z.: This question of being tender in love is a bone of contention in my family. My wife comes from an emotional family—always loving and kissing. My family is a good deal colder. We don't make a fuss over each other. We are colder in words, in endearment. We don't show our feelings much. I can't say "I love you," as often as my wife would like to have me do. For me to repeat it would be just words. Is it so urgent for me to put it in words? Can't she get it from my acts?

Mr. W.: I find it difficult to get words out. I have a most peculiar sense of guilt, when she says, "Do you or don't you love me?" I'm not good at expressing it or at simulating my feelings. They can't be summed up in just one word—love, but she is everything I want.

Mr. V.: We are living with her mother, and there's no privacy. No doors to the rooms. How can I make love to her under such conditions?

Mr. T.: It's different with me. We were always an affectionate family. It isn't hard for me to kiss my wife. I've done it all my life with my mother and father—yes, my father, too, until I was eighteen.

Many of the men ascribe their wives' inability to respond completely to their own sexual inadequacies. "It takes me only a minute or so," one husband says. "I am too quick—that's my trouble." Most of the men state that the duration of coitus on their part lasts from 1 to 3 minutes; some, however, can continue the sexual act for a long time—15 or 30 minutes, or even longer, and still their wives are unable to respond. "I try to hold out a long time, about a half hour or so," one man says, "but it is of no use. She can't come anyway, and at the end she urges me to finish." Another statement is "I can stay in for 10 or 15 minutes and even longer, but she just gets tired."

From the discussion that follows the men realize that it is not necessarily their own lack of control that is responsible for their wives' failure to respond, but that many women are unable to achieve an orgasm even though coitus is continued for a long time.

The men are quite frank in their discussion of their sex experiences before marriage, which many of them have had. Some, however, are aware that in their premarital relations they were not concerned whether their companion was or was not satisfied, but that with their wives the situation is entirely different. Now they are anxious to achieve a mutually satisfying relation.

At one of the sessions, the question came up whether a man should tell his wife about

his premarital relations. There was considerable difference of opinion:

Mr. Q.: Tell everything, and then they have no more questions.

Mr. P.: Well, my wife is continually asking about other women. I have always tried to change the subject, but a few weeks ago, after she kept on insisting, I tried to tell her something about an episode I had while I was in the army before I was married, and she got terribly upset.

Mr. O.: When we got married, we had a full cleansing of our souls on both sides. She took mine as a matter of course, but I found myself jealous. Is it a general tendency?

Mr. N.: I wouldn't like it. I wouldn't want anyone to put an arm around her but myself.

The last statement was made by a man who himself had had many sexual experiences before his marriage, and expresses the prevalent standards of the mores of the majority in the groups. They feel that it is quite acceptable for a man to have premarital relations, but object to similar experiences on the part of their wives.

Follow-up Sessions.—To evaluate the results of these group meetings, we arranged for follow-up sessions to be held 6 months later with each group. At this time, too, we met with the wives and husbands separately, although both groups came on the same evening. These follow-up sessions proved to be very helpful in determining what had been accomplished by the group therapy.

The reports of the groups revealed a significant change in attitude on the part of many of the wives and husbands. An awareness that they were not alone with their problem proved highly reassuring to most of them. Some also observed a marked improvement in their sexual adjustments, and a few of the wives stated that since participating in the discussions they had for the first time actually achieved an orgasm during sexual relations. There were several, however, who reported no progress in their physical adjustments, and in these cases further therapy was indicated and suggested.

A frequent statement by both the wives and husbands is that now they can talk much more freely to each other, and can understand each other's feelings more fully. Even though a complete response is not achieved, they learn to accept the situation with less tension and anxiety. A woman who had been seriously disturbed when she first came stated at the follow-up session:

When I first came here, we had almost decided to be divorced since we were having so much trouble sexually. We had then been living for months in a complete celibacy. Now, both of us feel better about it. My husband has improved very much, and I am much more responsive than I ever was. We know that we are not the only people having trouble.

And another woman stated:

I felt that I was all alone in an abyss. Now I find that I am not alone, and I can climb up the the ladder. Since I have come here, I have climbed up two rungs already. I am sure I am going to get to the top.

A wife who had a highly successful result said:

When I first was fitted with a diaphragm 6 months ago, the doctor asked me whether I had ever had an orgasm, and I said no. It is altogether different now. I get it every time, and I am very happy about it. I attribute it to the fact that I feel freer mentally, and that I am able to relax completely.

While many of the women had not yet achieved an orgasm during sexual intercourse, the feeling in the main was one of reassurance, acceptance, and hopefulness. Whether there is to be any further improvement in the physical response, and how long the changed attitude is to last is a matter of further observation.

CONCLUSIONS

On the basis of our observations, we believe that group therapy in sexual maladjustments produces the following results:

1. The most consistent and striking effect is the loss of the feeling of being isolated, of being different and inadequate.

2. Much release and reassurance is gained from the opportunity to talk freely without a feeling of disapproval or condemnation from the therapist and the fellow members in the group.

3. During the course of the several sessions, considerable insight into the nature of their problem is obtained by many couples. The ease of discussion at the meetings is often reflected in the ability of husband and wife to communicate more freely to one another their feelings and desires.

4. The members of the group become aware that sexual maladjustments are not

necessarily due to physical inadequacies, but may be traced to such factors as early experiences and conditioning, parental influences, and personality differences. These are often reinforced by difficult economic situations, housing conditions, in-law problems, and the like.

5. When husband and wife become aware of the many factors which may militate against a complete response, previous expectations are often broken down, and the situation is considerably improved. They find that sexual satisfaction can be quite acceptable even though a full response is not achieved. Some of the women actually succeed in reaching an orgasm, either clitoral or vaginal, after attending one or more sessions. This result is a source of much encouragement to the others in the group, and inspires them to persist in working out a more satisfactory adjustment for themselves.

SUMMARY

Group therapy in sexual maladjustment is a feasible and useful method. In some cases, it actually brings about a complete solution; in others, it serves to crystallize rapidly the areas of conflict. It affords the benefit that verbalization and catharsis have in clarifying a confusing problem. It relieves the feeling of inadequacy and isolation and provides an incentive for accepting a varying response. The group technique also emphasizes the universality of basic needs, as well as the uniqueness of the individual, and the resulting differences in behavior and attitudes to the same situation. This form of therapy, furthermore, offers a fertile field for research in the problems of sexual and other marital maladjustments, and can also be utilized in the training of students in the problems of marriage and the family.

STRATEGIC CONDITIONS IN THE PSYCHOTHERAPY OF PERSONS WITH SCHIZOPHRENIA [1]

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The purpose of this paper is twofold: (1) to focus attention on the *person* with a schizophrenic illness rather than on the schizophrenia itself; and (2) to consider some of the strategic conditions in the therapeutic situation that seem to contribute to the patient's favorable response. As has happened in other fields of medicine, so in psychiatry particularly with regard to psychotic patients there has been a tendency for the physician's interest in the disease to overshadow interest in the person who is ill. The failure to have maintained this distinction with psychotic patients is understandable, since the whole personality seems to be involved in the illness, and the disease and the personality come easily to be regarded as synonymous. Even with psychotic patients, however, some greater discrimination between the disease and the person seems not only possible but important as a basis for the strategic planning of psychotherapy.

In the case of schizophrenia, the idea that patients with this illness could be treated by a planned dynamic psychotherapeutic approach is little more than 30 years old. Skepticism as to the validity of this approach is still encountered but appears to be on the wane, and psychotherapy as a scientifically proper treatment for the schizophrenic patient seems well established by clinical evidence. The literature on the psychotherapy of schizophrenic patients surveyed in the next section reveals unanimity among the various authors that these patients are capable of relating themselves to the physician, and that this relationship is something more than just a "transference" relationship in the literal sense of this term, although this occurs too. In addition to, and acting to usurp, the transference relationship, these patients demonstrate a capacity, which is becoming increasingly recognized, to form a *different*, humanly more satisfactory relationship with the physician, a *new* reality experience that seems to be the medium for therapy.

A technical problem of prime importance is that of the development of a specific strategy of treatment that, when implemented by the physician in the psychotherapeutic situation, can be expected to effect significant improvement in the patient's life adjustment. This requires a clarification of the kinds of persons these patients are—the personal characteristics and issues that they share, perhaps with a special intensity, with the rest of mankind—and of the kinds of qualities in the physician that have a dynamic bearing on their specific therapeutic needs. It is with these general problems that the present paper is concerned.

Earlier Considerations of Strategy in the Psychotherapy of Persons with Schizophrenia

Early papers in which consideration is given to the recovery process in schizophrenic patients through psychotherapeutic techniques are those of Campbell (1913), Bertschinger (1916), Coriat (1918), Jelliffe (1919), and Kempf (1919).

Kempf's paper is the first to present a detailed discussion of dynamic strategic psychotherapeutic factors. He describes these patients as repressed introverted types who (p. 16): "through the consistent pressure often unwittingly exerted upon them by their intimate associates (family, teachers, masters, mates) have become influenced to repress their affective cravings from seeking those aggressive healthful, constructive outlets which constitute the behavior of normal people." He states (p. 17): "The individual's need for the esteem, the love and the respect of other particular individuals is the universal attribute of normal, gregarious man," and indicates that the person with schizophrenia also shares this human need. He stresses the helpfulness to the patient of an altruistic attitude in the physician which "never takes a negative turn." He refers (p. 58) to the "astonishingly reconstructive

[1] This discussion is based upon experiences with patients at The Henry Phipps Psychiatric Clinic of The Johns Hopkins Hospital, the Spring Grove State Hospital, and the VA Hospital at Perry Point, Md.

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results when an altruistic transference can be maintained. . . . . This requires upon the part of the physician, sincerity, insight, technical skill, self-control and the capacity to win confidence and control the transference."

Sullivan (1924) writes (p. 89): ". . . . far more than any single action of the physician, it is his general attitude toward the patient which determines his value." He comments that "primitive sympathy phenomena" are of prime importance in relieving the introversion of mental life of the patient, to such effect that his experiences can be brought more and more into objective relations, with the increasing adaptation of his personality to reality. In a later paper, Sullivan (1930) attempts a further definition of the personal characteristics of those taking care of schizophrenic patients (including attendants) to which the patients may be expected to respond with therapeutic benefit. He states that the encouragement of "intimate relationships" between the patient and the professional personnel is of basic therapeutic importance. He speaks of the mental hospital as (p. 982) "a school for personality growth rather than a custodian of personality failures." He describes as a basic personnel requirement a capacity for "consideration" of the patient, stemming from personal "sensitivity" that minimizes the possibility of "hurt" to the patient in daily human contacts and increases the probability of a "situation of sympathy." He writes (p. 988): ". . . . personality reorganizations of the type making for approximation to mental health are not outcomes of haste, humiliation and the like, but of affection and intimacy." He continues: "The sympathetic environment to which I refer is a group of persons, some 'psychotic,' some relatively 'sane,' in the latter of whom there is conscious formulation of community with the more disordered ones and a deliberate rather than a good-naturedly unconscious purpose to enter the life of the patient to a beneficial goal; this by reason of the *recognition of common motives, differentiated as to their manifestation by sole virtue* of different experience. Put somewhat loosely, the truly sympathetic person lives with the schizophrenic on a primary basis of assisting in the growth by experience of a body of *relatively undeveloped* tendencies to interpersonal relations; the situation is one of education, broadly conceived, not by verbal teaching but by communal experience —good tutoring." Sullivan (1931) reiterates this point when he says (p. 532): "From the start he is treated as a *person among persons.*"

Hinsie (1927) makes the point that schizophrenic patients who exhibit no interest in an environmental situation are in the minority and that "sooner or later" some interest in the physician will be shown. He feels that in the beginning the physician is in the role of a parent to a child; by the time the patient is ready to be dismissed, the physician's role has shifted to that of an "impersonal advisor" toward an adult. Hinsie comments that a more careful study of the means by which patients improve would undoubtedly reveal highly important factors.

Müller (1930) expresses the opinion that the concept of the incurability of schizophrenia is a fallacy. He states that the schizophrenic patient re-establishes contact with reality through a relationship with the physician and other persons, commenting that this has been a too little considered factor in healing. He states (p. 139): "Auf der einen Seite legen wir ein besonders Gewicht auf die affektiven Beziehungen des Kranken zum Arzt und zu einelnen Personen seiner Umgebung und erinnern an die bisher sicherlich unterschätzten Möglichkeiten einer richtigen Ausnützung der Übertragung." He points out that as the physician appreciates the wish-fulfilling needs of the patient's delusions and attempts to meet them in some real way, the patient becomes less absolute in his separation from reality and some compromise begins. The more such compromise is effected, the more the delusions decrease. Finally the wish-fulfillment needs are realistically met in terms of practical planning for the future.

Zilboorg (1930) notes that the patient perceives the physician as a real person as well as a transference figure. He feels that the patient should be given ample opportunity early in treatment to gain some sense of the physician's reality, referring to this as "reality testing." Once gained this is never lost, even though later the physician is "utilized as a sort of screen" on whom the patient's conflict is projected. Zilboorg feels that the patient's awareness of the reality situation prevents any escape into the former psychosis. He believes that lack of success in the treatment of schizophrenic patients would be less frequent if more care were devoted to the "reality principle" rather than to the "analytic situation" in the early phase of treatment.

Alexander (1931) refers to Zilboorg's emphasis on the necessity for a long preliminary period of reality testing in which the physician gains a positive relationship with the patient. He remarks that, if the essential fact can be established that the course of the psychosis yields to psychologic measures, there is a theoretical possibility that by the intelligent choice of psychic measures it can be influenced favorably. He comments that the neurotic person has to learn to accept repressed psychic facts, while the psychotic person has to learn to accept rejected external facts. He states that in psychotherapeutic treatment the persistent fostering of a "positive transference" will remain the most effective technical therapeutic device. He says (p. 825): "Psychotherapy for schizophrenia must be based on the systematic and intentional intensification of the positive transference, and also on the skillful steering of the further extension of positive feeling from the analyst to other objects."

Malamud and Miller (1931) state that the schizophrenic patient responds to the physician who is found to be "impartial" and who "respects" the reality of the patient's psychotic experiences, although always making it clear to the patient that he sees them as an overexpression of the patient's personal desires to the relative neglect of attention to the demands of the environment.

Fromm-Reichmann (1939) describes in some detail the human situation in which persons with schizophrenia find themselves. She reports that they are in a situation of distrusting everyone, of sensing the unreality and loneliness of their own substitute worlds, of longing for human contact and understanding but fearing further frustration. She describes them as readily disappointed in other people and constantly suffering from the experience of being misunderstood. She notes that these attitudes also enter into the relationship to the physician but that the patient is capable of developing a strong relationship notwithstanding. Fromm-Reichmann recommends that the physician not hurry the patient; that he try to understand the patient and let the patient know he is trying; that "superfluous interpretations and untimely suggestions" be avoided. She counsels that the physician offer the patient "complete acceptance" and that "arbitrary denials" be avoided. The physician needs to be free of fear of the patient and of counterhostility toward him. She states (p. 423): "It is certainly not an intellectual comprehension of the schizophrenic but the sympathetic understanding and skillful handling of the patient's and the physician's mutual relationship that are the decisive therapeutic factors." In a later paper (1948), Fromm-Reichmann adds (p. 265): "The schizophrenic is painfully distrustful and resentful of other people, due to the severe early warp and rejection he encountered in important people of his infancy and childhood, as a rule mainly in a schizophrenogenic mother. During his early fight for emotional survival, he begins to develop the great interpersonal sensitivity which remains his for the rest of his life. . . . Finally he transgresses the threshold of endurance." As the patient's motivations for his withdrawal from the outside world, she notes his fear of "repetitional rejection," his distrust of others and his own "retaliative hostility, which he abhors, as well as the deep anxiety promoted by this hatred." In this paper Fromm-Reichmann characterizes the person with schizophrenia as in part "a rejected child" and, in part, a person at "the level of his present chronological age." She counsels, therefore, against an attitude of "unmitigated acceptance" that (p. 266) "may be experienced by the sensitive adult schizophrenic as condescension or at least as lack of respect." She recommends, rather, an attitude "of acceptance of and permissiveness toward the regressive infant as part of the patient's personality, blended however with one of respect and understanding according to the patient's chronological age." In discussing the relationship between the physician and the patient, she discriminates accurately between those elements in the relationship that are in fact "transference phenomena" (recommending that these elements be used for analytic clarification) and those elements that (p. 267) "are an expression of the real, positive interrelatedness between patient and analyst." She feels that these real expressions do not need to be touched on by the physician and that "sooner or later the articulate schizophrenic will take care of their discussion by himself." Fromm-Reichmann recommends "clear directness" as a necessary device in dealing with disturbed schizophrenics. She states (p. 268): "Lack of spontaneity or overcaution may be more detrimental than faulty directness as long as the latter is serious and sincere in purpose." For the physician she recommends a state of mind that "is one of stability and serenity" and, as in her earlier paper, attitudes devoid of fear, anxiety, and counterhostility.

A paper by Ernst (1940) is of special interest because of her therapeutic optimism about the treatment of chronic patients. She states (p. 668): ". . . . of all the patients in a mental hospital, those who seem to me to be the most accessible to psychotherapeutic approach are the advanced schizophrenics." She recommends that the physician think of this type of patient as if it were a child at an age when a child creates definite fears for itself that then hold sway over it. The more intense the fear the more inarticulate the person is in speaking of it. She suggests behaving in a friendly manner with the patient and avoiding asking questions. The physician should take the initiative in indicating an understanding that the person is afraid, even by saying no more than the words "I understand." She does not crowd the patient and may deliberately keep her contacts infrequent. In her experience, the patient usually makes some move toward her. Thereafter it is (p. 672) "the listening more than the accurate understanding that is important." She comments (p.673): ". . . . one's intellectual reasoning power has no part in this therapy."

Federn (1943) distinguishes between "healthy and psychotic transference" and says (p. 251): "One wins the normal transference of the psychotic by sincerity, kindness and understanding." He states that the physician must avoid blame, severe admonition, any smiling superiority and especially any lie. He comments (p. 251): "Whenever the psychotic feels that you understand him he is yours." He adds: "The experience of good transference is the chief normal reality for the psychotic."

Eissler (1943) states that the therapist needs to establish (p. 385): "in himself that dynamic situation to which the schizophrenic would respond if it were offered to him." However, he feels rather pessimistic that this can be done in any planned way and focusses more on the obstacles precluding the establishment of such a dynamic situation than on defining it. He notes that the patient resents any conscious or unconscious attitude of superiority in the physician toward him.

Rosen (1946) believes that the general theme of fear motivates the behavior of persons with schizophrenia. He states (p. 195) that "the strong ego of the physician serves as a support for the weak ego of the patient. . . . . The physician must lend himself to the psychosis in such a role that the patient will finally trust him in order to leave his retreat for the world of reality." Rosen's tactical approach is to attempt to establish a relationship with the patient by himself dramatizing the "ter-

rifying images" of the patient and converting them into "protecting images." He comments that it requires more than a tender attitude and the administration of sympathy to relieve the patient's fear. In a second paper (1947), Rosen considers the physician's role, likening it to that of a good parent for a highly disturbed child. He states (p. 22): "The therapist, like the good parent, must identify with the unhappy child and be so disturbed by the unhappiness of the child, that he himself cannot rest until the child is again at peace." He adds: ". . . . the physician must have such a degree of inner security that he is able to function independently whether he is loved by the patient or not."

Knight (1946), in an exceptionally clear presentation of psychotherapeutic events in the course of treatment of a catatonic boy, states that the therapist (p. 324) "must go to the patient on the ward, actively build a relationship with him out of nothing, begin with him in whatever behavior and verbalization the patient shows, follow him with empathy in his irrational actions and attitudes, sit with him, walk with him, play with him, and strive constantly to understand and to let the patient know that he is trying. . . . . His therapeutic activity might be described as a flexible alternation between empathy and objectivity. To understand and to establish and maintain emotional contact with the patient he must empathize with him; to conduct the treatment he must be able to return to his objective role and do and say what will be therapeutically effective." With regard to treatment of the catatonic state, he writes (p. 338): "Therapy of such a state must, therefore, be a vigorous and persistent intrusion of the therapist into the patient's trance, forcing him to make contact again with an object. Affection, interest, sympathy—all the good attitudes of the good therapist may not be enough to pierce the daze, and must be supplemented by physical contact, an insistent voice, and a forcing of the patient to focus his attention on the therapist." He continues: "Optimism in the therapist is almost a *sine qua non* for successful psychotherapy. The patient cannot help but perceive it, just as he is equally sensitive to evidences of pessimism." Knight comments on the necessity for "active firmness" on the part of the therapist, stating that firmness "makes the patient feel more secure from his own 'bad' impulses if he can count on the therapist's adding his considerable strength in the struggle against the 'bad' impulses. Thus a too permissive or indulgent attitude on the part of the therapist may lead the patient to feel that he is without an ally, helpless against his own overwhelming hates, defiant feelings and primitive erotic wishes, and a prey to the intolerable anxiety they cause him. The protective strength of the therapist may thus be experienced by the patient as reinforcement of his own enfeebled ego, making it possible for him to contemplate eventual success in his struggle if this good ally will stay in the fight."

Betz, in two papers (1946; 1947), has seen the immediate technical problem in the psychotherapy of these patients as the resolution of the autistic barrier in the relationship between the physician and the patient. She observed that patients, once they had experienced a nonautistic relationship with another person, the physician, were able to function with increased spontaneity and broadened social participation with others; as the autism diminished, the schizophrenia did likewise. Betz has been interested in the dynamic characteristics of the autistic pattern. While recongnizing the "flight" aspect of this pattern as an expression of the patient's sensitivities and fears, she has regarded its antagonistic function as of perhaps more dynamic importance. She has observed that these persons are sensitive, not just to the harshness of the world, but also to the issue of supposed "control" or "influence" by others (a concept of the central dynamic issue in schizophrenia that Whitehorn has held for some time). Betz states (1947, p. 267): "The resentment of the influence which others are felt to exert upon him—sometimes fantastically exaggerated but basically true—provides the immediate issue for the schizophrenic alienation and gives positive form and color to the psychotic symptomatology. . . By withdrawing from emotional contact with others, the patient not only achieves ego-safety but also succeeds in frustrating the attempts of others to relate themselves to him and so retaliates in a measure by sabotaging the effectiveness of the 'influencing' pressures which he resents."

Myerson (1948) describes the "social anxiety" which plagues the person who develops a schizophrenic illness. He notes that, for most people, the social pressure of ordinary life arouses no especially disturbing feeling except on occasions, whereas, for other persons, the reactions of embarrassment or fear or hostility in the meeting of others may evolve into the symptoms of mental disease. He writes (p. 404): "They constantly feel that they are socially awkward, that what they say is inopportune and arouses derision and scorn. Yearningly they want the center of the stage, but they feel that all they can do successfully is to be a super who walks on, says a single line, and in a panic dashes off. In one form or another. . . the sense of being unable to reveal oneself properly and adequately is part of the social anxiety and constitutes one of the most formidable segments of the tormented inner life of these people."

Clinical Background

The observations to be reported in this paper have been derived from personal acquaintance with schizophrenic patients in a psychotherapeutic relationship. The patients whom I have studied as a participant-observer have been of 3 main groups: (1) A series of obsessive-schizophrenic patients whom I saw on an outpatient basis. The therapeutic experiences with the first 8 of these have been reported previously (Betz,

1946). There are now 16 patients in this series and their therapeutic response continues to be favorable. I have also had the opportunity of observing the course of therapy of several patients of this type who have been inpatients in The Henry Phipps Psychiatric Clinic in recent years. (2) Child patients diagnosed "infantile autism" as formulated by Kanner (1943), for the study of whom, for a time, a ward was made available in the Phipps Clinic. The experience with these patients has also been reported previously (Betz, 1947). (3a) Schizophrenic patients at the Spring Grove State Hospital in Catonsville, Md. (3b) Schizophrenic veterans at the Perry Point Hospital in Perryville, Md., where I have visited as a consultant during the past year. My intensive acquaintance with these patients now numbers 37. Since other obligations at Perry Point left me only one hour a week for the personal therapy of patients, I began to meet with several at one time rather than select one or two only for individual contact. However, even though we met in a "group" setting, I retained as my primary interest the relationship with the individual patients rather than working from the more sociological perspectives that focus on "group" dynamics. My primary concern was to see how I could participate as another individual in whatever pattern of relationship any individual patient seemed to be using, for the furtherance of the individual's feeling of personal significance in his own eyes and for an expansion of his spontaneity. Part of my technical chore was to participate in this way with the patients as individuals, within a general framework of equal human concern for all, and this was found not impossible to do.

The Person With Schizophrenia and Specific Strategic Conditions Requisite for His Recovery

On the basis of my own experiences as a psychotherapist with schizophrenic patients I believe that there are two requisite conditions in the treatment situation for a significant favorable response to occur. Both these conditions presuppose a person-to-person relationship between the physician and the patient, rather than a relationship between a medically trained mind and a disease. These two conditions may be stated briefly and then discussed in more detail. The first is that the physician exemplify in all his dealings with the patient the following *triad of human qualities:* kindness, strength, and fair play. These qualities need to be exemplified by attitude and action rather than by word; and they need to be exemplified not merely as abstract traits but with a professional grasp of how these specific human forces serve as dynamic therapeutic agents for these particular patients. Stating this condition from the perspective of the patient, the patient in his contacts with the physician needs to encounter a kind person, a strong person, and a fair person.

The second condition is that the physician have accurate knowledge in advance of the kinds of human situations that these patients have repeatedly encountered as their main life experiences and the kinds of feelings that have accompanied these situations, as the *talking* basis for the prompt establishment of an understanding personal acquaintanceship. Stating this condition from the perspective of the patient, the patient needs to encounter in the physician a perceptive person, competent to understand.

First Strategic Condition: The Physician as a Kind, Strong, Fair Person

One way that human beings have of sizing each other up is to "feel out," either deliberately or intuitively, the character of the other person's human qualities or values, what lies at the heart of his personality, what he exemplifies and is loyal to at his most sincere, what he rejects. The schizophrenic patient does this with the physician (as perhaps all patients do); and it is important for the physician to be aware of this exploration to which he is subjected and to be acquainted with those qualities that, when found, make him "valuable" to that patient. In using the term "qualities" or "values" I would discriminate between those usually associated with a person's conscience or super-ego and those that are an essential part of himself. The values of present concern are of the latter sort—attitudes and patterns of living

that are liked and spontaneously sought out and exemplified, rather than those adopted by social pressure, often against the individual's true grain, and adhered to as values one "should" have. Some of the qualities in the scheme of human values that persons with schizophrenia have consistently been observed to respect in therapy and to respond to participatively for their increased well-being may now be considered.

Kindness: These patients value kindness highly but do not expect to experience it personally. To them the kind person is almost a legendary figure. At moments in the therapeutic situation when, as happens, some kindness in the physician's attitude touches them, they are deeply moved. The patient may choke up for a moment, his eyes become moist, and he cannot speak. He may show surprise at the suddenness of his own emotional reaction, and struggles to get hold of himself again. Or the patient may relax suddenly, becoming briefly less strained and wary.

The word "kindness" as a technical therapeutic term deserves amplification. I use this term, not just in a descriptive sense to indicate a mildness or absence of harshness in the manner of one person toward another, but more in the dynamic sense in which it was recently used by Albert Schweitzer who stated that kindness as a phenomenon in human relationships is the strongest potential force in the world today, not excluding the atom bomb. In the psychiatric tradition of focusing on what is pathological and troublesome, attitudes of hostility for example have received more scientific definition than have the equally real but more constructive attitudes of kindness. In general, kindness and other constructive human attitudes have been scrutinized more from philosophical and moralistic than from scientific perspectives. A further knowledge of the dynamic nature of kindness as a constructive human force, based on scientific exploration of this phenomenon of human interrelationships, may be necessary before precise use can be made of it in therapy.

This quality of kindness is, essentially, the same quality that has repeatedly been reported as a necessary factor in the psychotherapy of schizophrenia patients under a variety of terms, such as altruism (Kempf), affection, consideration, sympathy (Sullivan), acceptance, permissiveness, and respect (Fromm-Reichmann), friendliness (Ernst), sincerity, kindness and understanding (Federn), concern for the patient's distress (like a good parent for a disturbed child) (Rosen). In this discussion, it is stressed less as a balm to the patient's wounds, although it is that too, than as a positive, tonic force whetting the patient's latent propensities for liking and participating in the human world around him. It is seen as a useful quality in itself, but with its therapeutic effectiveness multiplied when employed in conjunction with the other two qualities in the therapeutic triad, to be discussed next.

Strength: That the patient encounter the physician as a strong person, when this quality of strength is linked with kindness and fair play, is perhaps the most important single requisite of the therapeutic triad. Strength in itself, unassociated with these other two qualities, can have the effect of a noxious agent. It is therefore important that the physician comprehend the special significance of this quality to these patients so that he can plan his strategy with skill and confidence. The basis for such a dynamic understanding is provided by an acquaintance with the attitudes of these patients toward "strong" and "weak" human beings.

These patients respect and envy others who are strong in personality but they do not like or trust them. They despise weakness and reject as of no account anyone who they feel is weak. Lack of strength in the sense of wishy-washyness, being exploitable, yielding, turning the other cheek is a pattern they hold in contempt. They are concerned that they themselves are weak and they evaluate themselves with low self-esteem because of this quality. Much of their fantasy life and many of their patterns of delusion are concerned with being other than what they feel they are, with being what they value highly—strong and powerful in some respect. These patients do not like being pushed around and they do not respect anyone else (including the physician) who can be pushed around by others, particularly by themselves. While they do not like people who push others

around, they envy (value) the strength that enables them to do it and regard them as more significant people than the weaklings.

Whitehorn has stressed in a recent paper that it is not the strength of other people that these patients dislike but the *domination* that is, in fact, often associated with strength and that these patients consider to be inseparably so. This domination is expressed by a variety of coercive, superior attitudes and arbitrary efforts to control or influence, which do not take the receptivity or the sensitivities of the other person into account. Human nature is not invariably kind, as Myerson (1948) discusses in some detail, commenting on the surprising tendency even on the part (p. 405) "of children to follow someone who is sick, weak, ugly, and/or peculiar and to shout derisively at him, or even to hurl sticks and stones." The dilemma confronting these patients is that, when this resented domination is not prominent in another person with whom they come into contact, they tend automatically to regard him as a weakling. These patients are attracted only to strength, but they despise and fear domination. As long as these two qualities are seen as inseparable, these patients are psychologically incapable of establishing any sort of a close comfortable relationship with another person. On the contrary, they are committed to a policy of deep antagonism and resistance against the actual and supposed inimical forces around them.

This is the crucial psychological issue that confronts the physician in his first therapeutic contacts with these patients. With some patients it is less obvious than with others, although it is probably always present. It is ordinarily not expressed at a verbal level but is apparent in the patient's mode of participation. It can be particularly readily observed in the more aggressive articulate patients who at once begin to launch a campaign that tests the strength of the physician and his propensities to be dominating. Sometimes the tactics used by the patient seem to represent a deliberate exploration of the physician's personal attitudes and responses, with the patient as the "participant-observer" and the physician as the person being examined. The patient's tactics seem designed to get a "rise" out of the physician, to provoke counterattacks, to elicit defensiveness, to show up weakness and to entice a "brush-off." The patient may imperturbably ignore the physician; he may be socially rude; he may accuse him of unworthy and contemptible motives; he may be insulting; or facetious; or sexually forward; or obscurely abstract.

This initial period of examination of the physician by the patient is an important early phase in therapy. It is the period when true transference phenomena are actively in play and when, under strategic conditions that constitute a challenge to the validity of the transference attitudes the transference phenomena begin to be replaced by a genuine person-to-person relationship. The physician can participate in this period of examination by the patient with greater ease as he understands how the issue involved is rooted in the patient's deep concern about strength and domination. Very simply, what the patient is attempting (and expecting) to determine is whether the physician is a person who can be pushed around (a weakling to be ignored) or a person who is going to push him around (a person to be taken into account but to be sabotaged and held at a psychological distance). The therapist is in a key position to provide the patient with the beginning of a resolution of this dilemma by the manner of his participation and by the attitudes he reveals. He reveals himself as a person who does not let himself be pushed around and who does not do any pushing. He establishes himself as a strong person who is not dominant or coercive, but whose strength is associated with other positive qualities—qualities such as basic attitudes of kindness and fair play that are attractive to rather than rejected by the patient's value system.

It has been my observation that the patient experiences a considerable degree of stimulation, and even some enjoyment, out of the physician's active participation with him in this preliminary period of feeling each other out. The patient's self-respect seems to be enhanced by the fact that the physician does engage with him in this strenuous game, is simultaneously serious and good-natured about it, can take a lot of beating without really being hurt, and shows a continued willingness to carry on the acquaintanceship.

Actually, after the first few "brushes" with one of these aggressive articulate patients, the contest seems to lose some of its first deadly seriousness and becomes something of a game in which the physician begins to sense that the patient is finding him respectworthy and likeable, rather than a dreaded opponent.

Fair Play: The third quality that the physician needs as a strategic condition in the psychotherapy of schizophrenic patients is that of fair play. This quality is particularly akin to that of strength and together with kindness it helps to define the physician's strength as a force that can be utilized as a framework for growth rather than a dreaded force to be resisted. To most people the words fair play connote giving and getting an even break, receiving credit for what one deserves, keeping one's word, mutual respect for the individuality of others, and individual and social justice. Even though this concept is not realized 100% in actual experience, it is generally accepted as a basic premise by which people relate to each other. Persons with schizophrenia do not have much faith in this premise as an actuality and do not expect fair play in their dealings with others. Their deep concern about the *lack* of fair play in their own personal world and in the world in general is evidence of the high evaluation they place upon it. These patients are exquisitely sensitive to the injustices in life that most people either tolerate philosophically or about which they have only impersonal opinions. They bitterly resent the relative indifference of others to this issue in which they are so personally caught up. To them, too many abuses of justice pass through the wide-meshed nets of our laws, and the arm of formal justice is too short. As they see it, any person who does not exercise fair play in his dealings with others—who takes advantage of another person—is as deserving of punishment as a criminal, if strict human justice is to be done. They frequently feel almost more concerned with the lack of retaliation on the persons who abuse justice than on the injustice itself. Fair play comes almost to require "an eye for an eye"—a literally accurate but unusual understanding of the concept. It is not unlike the normal code of the small boy whose self-respect requires that, when hit by another boy, he hit back, harder if possible. These patients resent the blows they receive and despise their own incompetency in retaliating.

This issue of injustice (a failure of the premise of fair play) is not itself a "schizophrenic" issue, but a human theme that has preoccupied the great dramatists, novelists, statesmen, jurists, and leaders of people in all ages. However, in persons with schizophrenia, in contrast to most other individuals, it is a personal central theme that engages a great deal of their feeling and thought. In the beginning of their contacts with the physician they do not expect to find him a fair person. He is seen as a figure of authority—as indeed he is and must be— who is watched with wary expectance for the ways in which he will abuse his power. Attitudes of uneasiness, scorn, and cynicism are frequently exhibited. As, however, the patient finds that he gets a hearing, that the physician is interested in *him* as a person, respects the validity of his feelings (more important than sitting in judgment on his premises or his conclusions), is honest in his responses whether he agrees or disagrees, is concerned about his distress, is appreciative of his values however awkwardly expressed, and is not reproachful, punitive, or belittling, there is a beginning experience of fair play, of personal justice being maintained. Out of this experience the patient's sense of personal significance begins to grow and his confidence and spontaneity increase.

Second Strategic Condition: The Physician as a Perceptive Person Competent to Understand

Certainly patients in the first few months or years of a schizophrenic illness respond less autistically to the physician who approaches them with knowledge of their problems as persons rather than with interest in them as pathological curiosities. Later, it is true, some patients show a certain gratification at being regarded as an interesting "case" and display considerable genius in being psychotic. It may well be that the development of this latter attitude toward themselves can be more often aborted if interest in the human being rather than in the psychosis can be maintained from the start.

Like most people, schizophrenic patients are pleasantly intrigued when confronted by another person who is not taken in by their camouflage but seems to have some genuine understanding of them. Because of their habits of concealing their intimate feelings they are subject to much misunderstanding in the course of their lives. Consequently when someone with foreknowledge, not of the concrete details of their lives but of the characteristic situations they have repeatedly experienced and their feelings in these situations, confronts them, they are startled and their attention is engaged. Someone has said that "it is pleasant to be read like a book." This seems to be so with schizophrenic patients when the reader is a person whose basic interest is altruistic and human. Such a foreknowledge about these patients on the part of the physician now seems not only possible, but almost obligatory, since sufficient data have been reported about them to comprise a reliable body of facts. Some of those facts that have been found useful as issues that can be *talked about* fairly immediately in early contacts between the physician and the patient may now be reviewed briefly.

One of the dominant issues seemingly of universal concern to persons with schizophrenia is that of *social uneasiness,* of which they are fully aware, and the *lack of a feeling of personal significance,* which they appreciate having the physician perceive. As I have observed these patients, most of them share the usual human desire to be liked by others and to be respected, but their best efforts in this direction are ineffectual. That they have such desires and have made such efforts it is also pleasant for them to have the physician perceive. They feel that they do not know how to get along as other people do and are perplexed as to why not and what can be done about it. Usually they feel blameless for their social unpreparedness, and often this adds to their perplexity and distress since they do not know what needs correcting. An early indication from the physician of a sympathetic but matter-of-fact understanding of their longing for social ease, and of the dilemma in which their repeated distressing failures must have left them, often lays an immediate groundwork for a self-respecting and constructively oriented consideration with the physician of personal problems long ruminated about but never previously confided. Their mode of "confiding" is rarely in the nature of a confessional outpouring. It is more apt to be, at least at first, a confirmation of the physician's understanding as it applies to their experience, by the attentiveness with which they listen, by postural and facial attitudes of agreement, by substituting a more correct word for one which the physician has used, by completing a sentence, or by denial—"No, it was not that way; it was this way." It is because the physican's initiative is so often of vital tactical importance in the beginning that foreknowledge rather than ignorance may be of key importance.

Another important issue closely related to that of social unease is that of the extreme *self-consciousness* of these persons in the presence of others. This self-consciousness does not seem to be odd or strange in itself, but like that commonly experienced by everyone at some time in life in some unfamiliar social situation. These patients, however, can never "forget themselves" and become absorbed in what is going on around them. This ever-present self-consciousness makes any degree of social spontaneity impossible. As a consequence they feel and act timidly, stiff and rigid. Because of this extreme self-consciousness, the social problem is not just that of feeling overlooked or of being an insignificant presence in a group, but the more harrowing one of feeling themselves a ludicrous and conspicuous social failure. These individuals feel that their rigidity and inarticulateness are the focus of everyone's attention, and that anything they do or do not do is observed with derision (see Myerson, 1948, for a full consideration of this aspect of their problem) or callously ignored with deliberate indifference.

When away from other people and by themselves, these individuals feel some relief, which some tend to accentuate by pleasant daydreaming. Many of them, however, tend to brood about their social experiences retrospectively and in anticipation. Their inner feeling state is at times one of deep *humiliation* and chagrin. They are *frightened* at the prospect of humiliations to come. They are

bitterly *resentful* of those people who seem so easily to enjoy each other and are callous toward them. They are *lonesome* and often see themselves in the proportion of tragic figures, deriving some morbid comfort from this dramatization.

I have noticed that as, in the course of therapy, the patient acknowledges and amplifies on the distressing experiences he has had in life and as the physician responds as an attentive, sensitive listener, what occurs is not just a reliving or an accentuation of the painful feelings, but the emergence in the patient toward the physician of a new set of feelings that are warm and comforting. It seems to me to be the process of forming such a new relationship with another person that is of therapeutic significance rather than a working through of the old experiences or the acquisition of "insight" about them.

These issues that are so troublesome a part of the life experiences of these individuals seem to be somewhat in abeyance in a hospital setting and in the relationship to the physician. In some way a hospital and a physician are recognized, even by involuntary patients, as human institutions set up for persons in need of help and predicated on the rights of human beings to have help provided. In such a setting these patients seem automatically to feel some kind of rudimentary personal significance and their social role is partially defined.

One issue familiar in the life experience of these individuals that often remains active in the hospital setting is that of their sensitivity to being pushed around. Some patients have a very delicately balanced chip-on-the-shoulder attitude and react to the slightest suggestion from another person on the most routine matters as unwelcome attempts to coerce them. They are quick to anger and quick to resist, at least in attitude and at times in action. They resent the regimentation of hospital life; they resent the attendants calling them to various activities; they even resent the nurse suggesting that they might want a second helping of food. These patients may come to therapeutic conferences with hangovers of surly attitudes from recent experiences of the day, and sit in truculent silence or dispense caustic remarks about the hospital and the personnel. A rather prompt matter-of-fact comment by the physician on the obvious fact that they are sore about something, with exploratory nonmoralistic interest in what they are sore about, usually evokes a pertinent conversational response. They may often be induced to tell of other episodes in their lives where similar issues have arisen and in this way forward the personal acquaintanceship with the patient. In my experience it is usually better for the physician not to comment on or try to make something out of angry attitudes toward himself but to be somewhat obtuse about noticing them, or let them slide by. I have found that progress seems to be made when the physician continues walking quietly along with the patient even when the patient insists on walking out of step. Walking out of step with someone is less autistic than walking alone, and is one way of learning that the possibility of walking in step exists.

Case Material

The following case material is derived from my recent therapeutic experiences at the Perry Point Veterans Hospital where I met together with several patients at one time in weekly one-hour sessions. I did not acquaint myself in detail with the clinical histories of these patients, partly from a lack of time and partly from a desire to have the entire acquaintanceship between each of them and myself based on whatever exchanges took place between us. In retrospect this seems to have been a fortunate approach as in most instances I was gradually acquainted by the patient himself with his important biographical experiences and his attitudes toward them. The natural communication of these personal data was a part of the patient's therapeutic experience in being a person with another individual. Whatever I knew about him I learned from him; as he became better acquainted with the kind of person I was he communicated more about himself; and in the course of these events his sense of personal significance increased and his pathological autism diminished. In meeting with these patients in this setting I kept myself more or less "blind and deaf"

to their schizophrenic oddities of speech and behavior. I rarely commented on or inquired about such phenomena as hallucinations or delusions. I "sat out" long delusional harangues, listening attentively but registering no particular interest in exploring that line further. When I could detect an underlying issue with which the patient was struggling I would make an effort to restate what had been said in "English" rather than in "schizophrenic." I frequently said that I did not understand, and indicated an interest in further clarification, which often evoked a more lucid and personal response. I was immediately responsive and showed heightened interest whenever the patient said or did anything that was more on the human and less on the psychotic side. In general, I attempted to implement the strategic conditions that have been discussed in some detail above.

In closing, a brief abstract of the course of therapy with one of these patients is presented.

CASE 1.—J. V. This patient is a 25-year-old, single veteran with an eighth grade education who had been continuously hospitalized, first by the army and then in veteran's hospitals, since the onset of his psychosis 4 years previously. He had been a patient at the Perry Point Veterans' Hospital for 10 months prior to my acquaintanceship with him. His psychosis had developed shortly after he had been captured by the Germans at Aachen in the early winter of 1944. In the military hospital in Germany he had been diagnosed schizophrenic reaction, paranoid type. He had received 10 electric shock treatments without benefit. In October 1947 he had been transferred to the Valley Forge Veterans' Hospital, where the diagnosis of schizophrenic reaction, hebephrenic type was made. He was transferred to Perry Point in February, 1948. Here the diagnosis was schizophrenic reaction, catatonic type. A second course of electric shock treatments (16) had been without benefit.

When I first saw him he was on a closed ward where the more truculent, but not continuously disturbed, patients were cared for. He was surly, kept to himself, and was resistant and uncooperative toward the hospital routines. He wore a thick black beard as he would not permit the attendants to shave him. At times his behavior became so disturbed that he broke furniture, although he did not physically attack other patients or attendants. His personal physician was interested in him but a heavy case load had precluded any extensive personal psychotherapeutic contacts.

I first saw this patient on October 21, 1948, together with several other schizophrenic veterans. Between this time and his discharge 4 months later, February 23, 1949, there were 17 such meetings from which he absented himself 5 times. I therefore spent a total of 12 therapeutic hours with him. I saw him only once outside of the group setting and that was for a 15-minute individual conversation on the ward. During the first 5 meetings he was sarcastic and defiant in attitude and "tough" in manner. He spoke in a loud voice, deriding the Veterans' Administration, pensions, "robot doctors," and psychiatry. He referred to his hospitalization as his "imprisonment." In the first meeting, however, in the midst of a tirade, he said parenthetically to the physician: "No disrespect to you."

In the second meeting a week later he announced that he was there against his wishes and preferred to leave the room. However he stayed when told that there was no compulsion to do so but that "I can't get acquainted with you if you are somewhere else." During this second hour he blurted out challengingly: "How would you like to go to school in rags and be called a bum?" The physician responded that it sounded like a wretched experience. He then announced with a tough manner: "One and one-half years in the reform school." As the physician showed sympathetic interest, he divulged that his father had never shown any interest in him and his mother had thought him "a pain in the neck." In response to the physician's inquiry, he stated defiantly that his "best period" had been in combat where it was always "exciting" and he could "swear" freely.

During the third hour he lay stretched out on a sofa with his feet up and chin on chest, but was alert. He spoke of his resentment of authority and his low opinion of the world. Occasionally he swore. He was attentive to the remarks of the other patients and at one point got up unselfconsciously and came to the physician for a cigarette. During the fourth hour he again lay on the sofa, stressing that his presence at "this lecture" was not from his own desire. He continued to jibe at the Veterans' Administration and the "prison" hospital. He referred spontaneously to getting sick in Germany. He said: "Listening to the troubles of all these people only makes me feel worse."

At the fifth meeting he again arrived truculent and full of gripes. To the physician it seemed indicated at this time to function in relation to this patient somewhat more strongly as well as kindly. Accordingly the physician turned full attention on him suddenly and said, "You impress me as having a *terrible conscience*— you are so harsh toward everyone else, you must be just as harsh toward yourself and find yourself very hard to live with." He responded immediately in a quiet, natural voice: "I never thought of myself that way." He looked startled and thoughtful. His manner became less flip and defiant and was never so truculent thereafter. However, his next words were: "I just like to lie down drunk" to which the physician replied: "You are sensitive," and turned attention to another patient.

Comment.—This patient had been presenting himself as a tough guy, a bum. When this camouflage was challenged by the physician's skepticism

based on human appreciation for him as a person of value, he was touched and responsive.

During the remaining 6 hours of therapeutic contact with him he was increasingly quiet and serious, although still peppery and argumentative at times. His ward behavior also became quieter and he was sober in manner. His beard disappeared. At the sixth meeting he moved directly in front of the physician and engaged in serious talk although skeptical and scornful attitudes were still expressed. He stated that he "was liked" by his buddies in the army. The physician responded that this seemed understandable to her. The physician then remarked that he had had some opportunity for acquaintanceship with her and he acknowledged that he did not "mistrust your kindness." He participated in some discussion of the practical goal of financial "independence" (his word) and of the possible practical use of some of his "critical skills" (the physician's words). He was more poised in manner and less touchy.

He absented himself from the next meeting (the seventh). The following week the physician made the only individual contact with him of the treatment period, visiting him for 15 minutes on the ward some hours before the regular meeting was scheduled. He was courteous and serious, and in response to the physician's real interest, told of his First Army experiences, his capture at Aachen ("at least I got that far"), the invasion of Africa ("I vomited"), and of feeling burdened at the extra responsibility of being promoted to sergeant shortly before his capture ("I was so tired"). He stressed that he was still "tired." Although the physician did not urge him to come to the regular meeting that day and, in fact, suggested that he might prefer to remain on the ward and "rest," he was the first to arrive and continued to talk personally of his life. He told of his early life in a mining town, of being the third of 4 brothers, of the death of both of his parents before he was 8, of playing hookey from school and being sent to the reform school. He had had to work from the time he was young. He had hated the mines but known nothing of the world outside of his town. He had enlisted at 18. On the physician's inquiry as to anyone with whom he had felt somewhat natural and comfortable, he mentioned an aunt and a cousin in Baltimore for whom he had some liking and who he thought had some liking for him.

He absented himself from the ninth meeting. At the tenth he was quiet and serious, continuing to stress his "tired" feeling. He was still touchy but responsive and smiled spontaneously once or twice. He exchanged some remarks with another patient in a good-humored way. He said: "I will do a laboring job when I leave here." He absented himself from the next 2 meetings (the eleventh and twelfth), and appeared the next week only to leave early with a not-unfriendly manner. The next week (fourteenth meeting) he stayed through the hour, participating actively. He stressed that he did not want to be "an aristocrat," as though to disabuse the physician of any such expectations of him. He spoke of not having much education, of needing excitement, of being restless. He would like "5 years in the world with no responsibilities." He expressed scoffing attitudes toward his "old man." He spoke of the practical possibility of living with his aunt for a time in Baltimore. During the following week he began, for the first time, to attend occupational therapy classes. The following week he was again absent.

At the next meeting (the sixteenth) he participated actively. He said: "I had a rough life—I used to be scared." He stated resentfully: "People try to tell me what to do." He depicted himself as a generous person who would give his last nickel to anyone. The physician expressed respect for this quality and commented on the problem of recognizing it in other people toward oneself, as well as in oneself toward other people. The patient also characterized himself as responsible toward others (citing his care, while in Europe, not to include the young boys in his outfit in his own tough doings in periods of leave. "I went by myself.") He said that he was "mentally sharp" when at his best. He smiled more and looked self-respecting. The physician mentioned that some people might be "for him" rather than "against him" just as he had been "for" his buddies.

The patient was discharged from the hospital during the week following the next meeting (the seventeenth since he had begun treatment but the twelfth he had attended). During this last meeting, he participated actively in discussions with the therapist. He continued to "shift out of step" with the therapist in discussions, but seemingly more on the principle of being independent in his own views than out of real disagreement or antagonism. The physician commented on this, wryly but bluntly, in terms of the possibility that increased *tact* in dealing with others, particularly during the period of getting acquainted, might be of advantage to him; that others might misunderstand him as really quarrelsome and become unnecessarily antagonistic.

Discussion

From my experience in the clinical teaching of medical students and of physicians in psychiatric training, I feel justified in the opinion that the perspectives on schizophrenic patients and the strategic principles for treatment that have been presented here are within the capacity of most physicians to comprehend and to implement tactically. These perspectives and principles, while still general and subject to technical refinement, have been gradually formulated by the well-documented work of a number of clinical investigators and provide a working orientation from which a favorable therapeutic response may be expected. I do not believe that any special talent, or any special eccentricity of personality, is required for a phy-

sician to be a helpful therapist with schizophrenic patients, as is occasionally said. Indeed, physicians with special eccentricities of personality who are effective therapists with these patients are probably so in spite of, rather than as a consequence of, their eccentricities. Any physician who approaches his work with humility, intelligence, and a sober enthusiasm for therapy, and who has a capacity for steadfastness, can be trained or train himself to participate in a personal relationship with these patients to their therapeutic benefit. His special task is the appreciation of those personal qualities in himself that are of dynamic value to persons with schizophrenia and the intelligent cultivation of their expression in the personal relationship with the patient.

BIBLIOGRAPHY

1. Alexander, F. Schizophrenic psychoses: Critical considerations of the psychoanalytic treatment. Arch. Neurol. and Psychiat., **26**: 815, 1931.

2. Bertschinger, H. Processes of recovery in schizophrenics. Psychoan. Rev., **3**: 176, 1916.

3. Betz, B. J. Experiences in the psychotherapy of obsessive-schizophrenic personalities. So. Med. J., **39**: 249, 1946.

4. Betz, B. J. A study of tactics for resolving the autistic barrier in the psychotherapy of the schizophrenic personality. Am. J. Psychiat., **104**: 267, 1947.

5. Campbell, C. M. The treatment of dementia præcox and allied conditions. Chap. 13 in Modern Treatment of Nervous and Mental Diseases, ed. by White and Jelliffe, 1913.

6. Coriat, I. H. The treatment of dementia præcox by psychoanalysis. J. Abnorm. Psychol., **12**: 326, 1918.

7. Eissler, K. B. Limitations to the psychotherapy of schizophrenia. Psychiat., **6**: 381, 1943.

8. Ernst, M. G. Psychotherapeutic approach in schizophrenia. J. Ment. Sci., **86**: 668, 1940.

9. Federn, P. Psychoanalysis of psychoses. Psychiat. Quart., **17**: 246, 1943.

10. Fromm-Reichmann, F. Transference problems in schizophrenics. Psychoanal. Quart., **8**: 412, 1939.

11. Fromm-Reichmann, F. Notes on the development of treatment of schizophrenics by psychoanalytic psychotherapy. Psych. **11**: 263, 1948.

12. Hinsie, L. E. The psychoanalytic treatment of schizophrenia. Psychiat. Quart. **1**: 313, 1927.

13. Jelliffe, S. E. Psychotherapeutic technique through psychoanalysis. Psychoanal. Rev., **6**: 1, 1919.

14. Kanner, L. Autistic disturbances of affective contact. The Nervous Child, **2**: 217, 1943.

15. Kempf, E. J. The psychoanalytic treatment of dementia præcox: Report of a case. Psychoanal. Rev., **6**: 15, 1919.

16. Knight, R. P. Psychotherapy of an adolescent catatonic schizophrenic with mutism. Psychiat., **9**: 323, 1946.

17. Malamud, W., and Miller, W. R. Psychotherapy in the schizophrenias. Am. J. Psychiat., **88**: 457, 1931.

18. Müller, Max. Über Heilungsmechanismen in der Schizophrenie. Abh. aus der Neur., Psych., Psychol. u. Ihren Grenzgebieten. Monatsschrift 57. Berlin (S. Karger) 1930.

19. Myerson, A. Scrutiny, social anxiety and inner turmoil in relationship to schizophrenia. Am. J. Psychiat., **105**: 401, 1948.

20. Rosen, J. N. A method of resolving acute catatonic excitement. Psychiat. Quart., **20**: 183, 1946.

21. Rosen, J. N. The treatment of schizophrenic psychosis by direct analytic therapy. Psychiat. Quart., **21**: 3, 1947.

22. Sullivan, H. S. Schizophrenia: Its conservative and malignant features. Am. J. Psychiat., **81**: 77, 1924.

23. Sullivan, H. S. Socio-psychiatric research. Am. J. Psychiat., **87**: 977, 1930.

24. Sullivan, H. S. The modified psychoanalytic treatment in schizophrenia. Am. J. Psychiat., **88**: 519, 1931.

25. Whitehorn, J. C. Lecture and personal communication.

26. Zilboorg, G. The deeper layers of schizophrenic psychosis. Am. J. Psychiat., **88**: 493, 1931.

COMPLICATIONS OF ACUTE CATATONIC EXCITEMENT [1]

A Report of 2 Cases

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Acutely excited psychotic patients not uncommonly collapse and die. This experience is extremely disquieting to the physician and to the pathologist, who is equally frustrated, since no adequate explanation is found at necropsy to account for the death.

This syndrome was first reported by Calmeil(2) in 1832. He described severely disturbed patients who were experiencing vivid auditory hallucinations. Some of these patients suddenly changed from wild, hyperactive states to profound stupor and quickly died with terminal hyperthermia as high as 110° in a few minutes to a few hours. He added, "The autopsy reveals nothing." The syndrome has been variously named: cyanotic syndrome (Scheid, 8), fatal catatonia (Stauder, 12), and exhaustion syndrome (Shulack, 11).

The course of the typical case was divided into 3 phases by Billig and Freeman(1). First, the prodromal phase lasts a few days to several months. At the onset of this period a change in personality is noted. Then develop gradually increasing excitement, restlessness, agitation, hallucinations, and delusions. The second phase is ushered in with intense, wild agitation and violent, destructive behavior. The patient then literally demolishes everything in sight, tears furniture into small pieces and, in the height of maniacal furor, rushes headlong into bizarre suicidal attempts. This phase lasts a few minutes to several days. Physical examination reveals a rapid pulse, subnormal blood pressure, profuse perspiration, weight loss, and frequently cyanosis of the finger tips. The temperature may be at 100° rectally. The third phase is initiated with sudden peripheral circulatory collapse; the systolic blood pressure is at shock levels with narrow pulse pressures, and the pulse is rapid and thready. The temperature mounts rapidly and may reach 110° (R) in a matter of minutes. The behavior remains sporadically violent alternating with grades of stupor. Death supervenes in a few minutes to 8 days with abrupt cessation of cardiac and respiratory action.

Autopsy reveals nothing more than the usual nonspecific findings after more or less prolonged circulatory collapse. Rare cases show massive hemorrhage in vital cerebral areas, as in the case reported by Murphy and Neuman(5).

Shulack(9, 11), in a series of 3 articles, reviewed the literature up to 1944 and found 403 reported cases, all fatalities. He added 9 cases of recovery and delineated treatment. This consisted mainly of the following: 1. Early recognition of the syndrome and institution of treatment before the temperature rises. 2. Adequate sedation by chemical and physical means. 3. Adequate nourishment by tube feeding and intravenous fluids. 4. Sodium replacement. 5. Regular administration of adrenal cortical extract. Shulack exhaustively reviewed the theories of etiology. He emphasized mechanico-functional factors superimposed on a labile parasympathetic nervous system and a constitutionally inadequate cardiovascular mechanism(4).

This syndrome is confined to the functional psychoses, usually schizophrenia. Cases have been reported as manic-depressive and involutional psychoses, but the reported content of these patients is suggestive of schizophrenia.

The purpose of this paper is to report 2 additional cases that present not only the typical syndrome of acute catatonic excitement but unique complications not heretofore described in the literature.

Case 1.—T. H., a 30-year-old robust white male, was admitted to the hospital after 3 days of ma-

[1] From the neuropsychiatric section of the National Naval Medical Center, Bethesda, Maryland. The opinions or assertions contained herein are the private ones of the authors and are not to be construed as official or reflecting the views of the Navy Department or the Naval Service at large.

niacal and grossly bizarre behavior. This consisted of ever-mounting excitement, auditory hallucinations, and delusions of omnipotence. The attack culminated in an acute destructive furor in which he tore to bits most of the furniture in his home.

Neuropathic heredity included 2 cousins and a great-aunt who had been committed to mental hospitals. Social service investigation documented 3 previous hospitalizations for psychotic episodes. The first, at the age of 18, followed an acute aggressive excitement in which he threatened numerous people with a rifle. At this time confusion, euphoria, auditory hallucinations, pressure of speech, and increased psychomotor activity were apparent. He recovered in 3 months, was diagnosed catatonic schizophrenia. The second occurred at the age of 22 when he became depressed and attemped suicide by plunging an ice pick into his chest. Details of this hospitalization could not be obtained. The third hospitalization occurred at the age of 24 when he became hyperexcitable, hallucinated, aggressive, and negativistic. He recovered in a few months and was discharged with the diagnosis dementia præcox, simple type. In the intervals between psychotic episodes his family considered him normal with only occasional evidence of erratic behavior. On one occasion, without apparent provocation, he threw a knife at his wife, barely missed her head, and then beat her unconscious.

On the present admission the patient was reacting violently to vivid auditory hallucinations. He was confused, irrelevant, and autistic. Flight of ideas, pressure of speech and action, and dissociation of affect were exhibited. Physical examination was within normal limits; he appeared well nourished and hydrated. Neurological examination revealed no abnormalities. The temperature was 99.4°, pulse 82, and blood pressure 130 mm. Hg systolic and 90 mm. Hg diastolic. Admission laboratory studies consisting of blood serology, urinalysis, complete blood count, and chest roentgenogram were within normal limits. The patient became gradually more excited and hyperactive, talked disconnectedly, and rolled about on the floor. Temporary relief was obtained with wet packs, continuous tubs, and barbiturate sedation. He took adequate nourishment until the eighth hospital day when he reached a peak of purposeless destructive mania. He smeared and threw feces and ran aimlessly about his room. He was placed in a wet pack for three hours and, when removed, had an axillary temperature of 101°. Thirty minutes later acute collapse occurred. The temperature was 106° rectally. In spite of the hyperpyrexia, the skin was cool and of good turgor. Respirations were 40 per minute, pulse 160, and blood pressure 80 systolic with an unobtainable diastolic. No other abnormalities were found on physical and neurological examinations. An electrocardiogram showed sinus tachycardia with an auricular rate of 110. An electroencephalogram was not entirely satisfactory because of the patient's excitement but revealed no gross evidence of a space-occupying lesion. White blood corpuscles were 21,800 per cubic millimeter with a relative increase of polymorphonuclears. A blood culture was negative. The patient was placed in continual sheet restraints, started on prophylactic antibiotics and parenteral fluids, and was sedated with intramuscular paraldehyde. On the next day the temperature varied hourly from 100° (R) to 104° (R) and the blood pressure, without any apparent relation to temperature, varied from 100/70 to 70/60 usually at the lower levels with narrow pulse pressures. As often as was safe, the patient was kept unconscious with intravenous barbiturates. Since Nardini and Vestermark(6) reported good results with electroconvulsive therapy in 2 similar cases, it was decided to attempt it in this patient in an effort to ameliorate the acute excitement. He was given an initial shock of 450 milliamperes at 0.3 second without any apparent effect. The patient went right on talking, did not even become cyanotic. Immediately thereafter he was given another shock of 600 milliamperes at 0.3 second and again showed no motor seizure or cyanosis, but turned over and went promptly asleep. Later that day his condition rapidly deteriorated. A lumbar puncture revealed clear fluid under an initial pressure of 40 mm. of water with normal manometrics. Blood carbon dioxide combining power was 36 volumes percent. Blood studies indicated hemoconcentration, and the hematocrit was 59 percent volume packed cells. The urine contained 30 mg. % of albumin, was negative for sugar but positive for acetone and diacetic acid. There were no pus cells, and a test for porphyrins was negative. The patient went into almost continual peripheral vascular collapse and developed cyanosis of the extremities. The temperature fluctuated between 104° (R) and 106° (R). In that day, the second day of the hyperpyrexia, the patient received 5,000 cc. of parenteral fluids of which 500 cc. were plasma, 1,000 cc. parenamine, 1,000 cc. 5% dextrose in normal saline, and 2,500 cc. 5% dextrose in water. In addition to antibiotics, barbiturates, and large doses of vitamins, he was given adrenal cortical extract in divided 1-cc. doses. Practically continuous alcohol sponge baths were administered. On the next day, the third day of collapse, the temperature fell to 103° (R), and the blood pressure rose out of shock levels. Albuminuria and ketonuria continued with the additional finding of occult blood in the urine without red cells. Bleeding, coagulation, and prothrombin times were within normal limits. A roentgenogram of the chest was negative. In his conscious intervals the patient continued psychotic, stated that his name was Jesus Christ. On the fourth day the temperature came down to 100°, and the blood pressure gradually rose to 130/80. Urinary output on that day was only 13 cc. The urine was negative for ketone bodies, contained 120 mg. % albumin. A complete blood count was within normal limits. On the fifth day the patient appeared remarkably improved clinically but was in complete renal shutdown. The acute excitement had subsided. Although productions were still bizarre, and hallucinations occasionally occurred, he was well oriented and talkative. The blood pressure rose to 140/80, and

considerable edema developed rapidly. The nonprotein nitrogen was 180 mg. per 100 cc., and the blood urea nitrogen 150 mg. per 100 cc. The patient was considered to be in lower nephron nephrosis as a complication to the long period of peripheral vascular collapse. He was started on a regimen of fluid intake, containing at least 100 grams of dextrose daily, and limited to the amount necessary to replace insensible fluid loss(13). The fluids consisted of 10% dextrose in water with calcium gluconate added. On the sixth day there was again no urinary output. Temperature remained normal. The nonprotein nitrogen reached 210 mg. per 100 cc. Total plasma proteins were 6.1 grams per 100 cc. with 3.9 albumin and 2.2 globulin. The blood carbon dioxide combining power was 36 volumes percent. Blood calcium was 10.5 mg. per 100 cc., creatinine 5.8 mg. per 100 cc. Near the end of the seventh day, after 3 days of anuria, diuresis began. There was almost complete clearing of the psychotic picture at the same time. The patient was well oriented, rational, and cooperative. There were no hallucinations or delusions. He was still mildly hypomanic, however, and occasionally exhibited flight of ideas. In the next week all blood chemistries and counts, as well as urinalyses, returned to normal. Five days after recovery from anuria the patient again became overactive, confused, rambling in speech, and silly in affect. Productions were replete with sexual content, and he made nearly overt homosexual advances. He denied that he had been ill and demanded release. Temperature and vital signs remained stable within normal limits. In an effort to prevent recurrence of the excitement he was given a course of 5 electroconvulsive treatments, each producing a grand mal seizure. The excitement subsided, and the patient returned to what his relatives considered his pre-illness personality. He was amnesic for most of the events of his illness but remembered that the psychotic episode was initiated by a remarkable feeling of well-being, as if "I was in heaven on earth," and by uncontrollable impulses to keep moving. When informed of his remarkable recovery, he said that he had become convinced in his early youth that he was to die in his thirtieth year and would not feel secure until he reached his thirty-first birthday.

The psychiatric picture after recovery was characterized by persistent mild euphoria, mild silliness of affect, and marked circumstantiality. Rorschach, Bender Visual Motor Gestalt, and Wechsler-Bellevue Tests revealed typical findings of a chronic schizophrenic process without evidence of organic damage. Neurological and systemic examinations were negative. An EEG revealed a minimal generalized abnormality that was considered residual of the acute illness. There was no clinical evidence of lability of the thermal regulating mechanism; a 2-week temperature chart showed no significant fluctuations. As far as could be determined, previous febrile illnesses were not unusual. There was no clinical evidence of vasomotor instability, and cold pressor tests were within normal limits. Intravenous pyelograms were normal. Kidney function studies revealed a slight residual loss of renal concentrating ability. A Kepler-Power Water Excretion Test was within normal limits.

CASE 2.—H. D., a 36-year-old white male, was admitted to the sick list after 13 days of active naval service with complaints of insomnia and irritability of 10 days' duration. On admission the patient was disoriented, tense, tremulous, tearful, and agitated. Emotional responses were grossly inappropriate to the material discussed. Content of speech dealt mainly with his "sins" and prayers for forgiveness. Although wishes for death in atonement for his "sins" were expressed, he described his mood as "happiness and complete and holy joy." Physical and neurological examinations disclosed no pathological findings. Laboratory examinations consisting of blood serology, urine analysis, complete blood count, sedimentation rate, and roentgenograms of the skull and chest were within normal limits. For the first few days of hospitalization he was untidy, urinated on the floor, expectorated on the walls and other patients, and insisted that he was well. Silly and inappropriate behavior continued with more pronounced grimacing, untidyness, and ideas of self-reference. As agitation increased, threats of self-destruction became more frequent. On the eighth hospital day, incidentally his birthday, he suddenly went into a stage of acute excitement and threw himself violently about his room. At the height of mania he attempted to mutilate himself, was restrained from manually tearing off his genitalia. He was intensely aggressive and combative. For this reason he was placed in sheet restraints, which he fought ceaselessly. One hour after the onset of acute excitement he suddenly initiated the following chain of events. He inhaled deeply, extruded his tongue, clamped his teeth down upon it, held his breath, and struggled violently. Apneic episodes of approximately one minute duration alternated with one minute intervals of respiration. Cyanosis accompanied the apnea. Utilization of a tongue gag was only partly successful in the prevention of tongue biting. After about 5 minutes of this behavior, in the midst of an apneic episode, cardiac arrest occurred. Artificial respiration and intravenous stimulants were promptly used, but without effect. The final phase of excitement, mutilative attempts, and voluntary apnea lasted about one hour. The clinical diagnosis was schizophrenia.

At necropsy, the direct cause of death was considered to be asphyxia although no anatomical cause for the asphyxia could be found. The gross pathology consisted only of (1) congestion and edema of the glottis without occlusion of the airway, (2) marked congestion and moderate edema of the lungs, (3) a pleural petechial hemorrhage, (4) slight meningeal edema, and (5) moderate congestion of the parenchymatous organs. The heart was normal. The brain showed only moderate vascular congestion. Microscopic findings were consistent with the gross pathology.

COMMENT

The two cases reported are considered worthy of addition to the literature because of the unusual features of their complications. The unusual features of the first case are as follows: (1) Fatality was averted despite the long duration of shock, acidosis, and hyperpyrexia. The temperature elevation (106°) is the highest yet reported in a nonfatal case of the "exhaustion syndrome." It would appear that the remarkably high mortality rate in this syndrome might be reduced appreciably with early institution of proper treatment. (2) The use of electroconvulsive therapy in this patient is worthy of mention. It proved unsuccessful in the amelioration of excitement during the "exhaustion syndrome." In fact, the patient's condition went rapidly downhill after shock. It appeared useful, however, in the prevention of a possible recurrence later. Reasons for the patient's failure to convulse when first treated are not apparent. Elevation of the shock threshold by previous administration of barbiturates may have been a factor. (3) Of special interest is the development of lower nephron nephrosis, apparently as a sequela of the long period of peripheral vascular collapse. This complication has not previously been reported in this syndrome. However, as more cases recover, it may be encountered more frequently. Its development should be anticipated in these patients so that at the first sign of oliguria and azotemia appropriate changes in the treatment regimen can be made. Once renal shutdown occurs, to continue administration of the large amounts of parenteral fluids and electrolyte required for treatment of the "exhaustion syndrome" greatly increases the danger of death from pulmonary edema, ever-present in lower nephron nephrosis.

As regards the second case, a search of the literature fails to reveal any previous reports of death in voluntary apnea. Indeed, such a state is generally considered a physiological impossibility. Rosenblum and Silverman(7) reported a similar, though nonfatal case. A suicidal, excited catatonic patient voluntarily held his breath and performed the Valsalva experiment (deep inspiration followed by forced expiration against a closed glottis). Mediastinal and subcutaneous emphysema rapidly developed. This activity was interrupted by the administration of anesthetic agents.

The two patients presented are considered similar in that both were typical excited catatonics with well-established patterns of violence directed toward the environment and the self. When prevented from destructive behavior at the peak of furor, one developed the "exhaustion syndrome" with near fatality; the other died in voluntary apnea. One might question whether these developments were accidental or whether they were actually an integral part of the patient's illnesses. The lethal power of the emotions (3) is a concept well-established in psychosomatic medicine. The question raised here is that of motivation. That is, did these patients, at a conscious or unconscious level, desire death? If so, was this desire translated into the complications that they developed when the usual forms of suicide were prevented? In the second patient, the premise that his motivation was suicidal is strengthened by his threats of self-destruction, abortive attempts at self-mutilation, and, finally, his voluntary breath-holding. Whatever the mechanism of his cardiac arrest, such as the possibility of an irritable carotid sinus reflex producing fatal syncope, he accomplished his death on the fertile soil of whatever physiological deficits he had. In the first patient, evidence for the motivational development of the complication (the "exhaustion syndrome") is not as clear. Suicidal propensities, however, were present as manifested in his earlier attempt with an ice pick. Furthermore the onset of collapse and hyperthermia occurred at the height of furor while restrained from overt destructive behavior.

The case reports in the literature are replete with references to behavior that the observers considered suicidal. In the light of this, and from the data presented in this paper, it is suggested that suicide may be accomplished at a physiological level. The authors recognize that such a concept is highly speculative but suggest that it warrants further consideration and investigation.

SUMMARY

1. Two cases of acute catatonic excitement with unusual complications are presented.

2. The first case survived a stormy course of peripheral vascular collapse, acidosis, and hyperthermia to 106°. Recovery was complicated by the development of lower nephron nephrosis.

3. The second case died in the course of voluntary apnea. This is the first such case to be reported.

4. It is suggested that suicide may be accomplished at a physiological level.

BIBLIOGRAPHY

1. Billig, O., and Freeman, W. T. Fatal catatonia. Am. J. Psychiat., **100**: 633, March 1944.

2. Calmeil, cited by Ladame, C. Psychose aiguë idiopathique ou foudroyante. Schweiz. Arch. f. Neurol. u. Psychiat., **5**: 3, 1919.

3. Gregg, Donald. The lethal power of the emotions. Ment. Hyg., **20**: 30, January 1936.

4. Lewis, N. D. C. Constitutional factors in dementia præcox. Nerv. and Ment. Dis. Monographs, No. 35.

5. Murphy, J. P., and Neuman, Meta A. Fatal cerebrovascular accident associated with catatonic schizophrenia. Arch. Neurol. and Psychiat., **49**: 724, 1943.

6. Nardini, J. E., and Vestermark, S. D. Exhaustion delirium. In preparation. Personal communication.

7. Rosenblum, M. P., and Silverman, J. J. Self-induced mediastinal emphysema in a psychotic. J. Nerv. and Ment. Dis., **105**: 414, 1947.

8. Scheid, K. F. Febrile Episoden bei schizophrenen Psychosen: eine klinische-pathologische Studie. Thieme, 1937.

9. Shulack, N. R. Sudden "exhaustive" death in excited patients. Psychiat. Quart., **12**: 282, April 1938.

10. Shulack, N. R. Sudden "exhaustive" death in excited patients. Psychiat. Quart., **18**: 3, January 1944.

11. Shulack, N. R. Exhaustion syndrome in excited psychotic patients. Am. J. Psychiat., **102**: 466, January 1946.

12. Stauder, K. H. Die tödliche Katatonie. Arch. f. Psychiat., **102**: 614, 1934.

13. Strauss, M. B. Acute renal insufficiency due to lower nephron nephrosis. New Eng. J. Med., **239**: 693, Nov. 4, 1948.

A FOLLOW-UP STUDY OF MOTOR WITHDRAWAL REACTION TO HEAT DISCOMFORT IN PATIENTS BEFORE AND AFTER FRONTAL LOBOTOMY [1]

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Studies from this laboratory revealed that during the first postoperative year lobotomized patients tolerated less readily heat discomfort than before operation(2). The stimulus employed was increasing intensities of light applied to the forehead by the Hardy-Wolff-Goodell pain threshhold apparatus. Significantly less intense application of measured heat, after as compared to before lobotomy, caused the patient both to pull the head away from the apparatus and to wince. This observation was unexpected since frontal lobotomy has become a recognized procedure for the relief of intractable pain(3-8). No explanation could be given for the apparent discrepancy between the therapeutic effectiveness of the operation and these experimental findings. The decrease in the significance of the results obtained during the second 6-months as compared to the first 6-months postoperative period made us feel that we should be alerted to the fact that the observations might represent only a temporary change after lobotomy(2). The findings during this follow-up study, which covers the second postoperative year, seem to have confirmed this impression. As mentioned in our previous communication, subjective reports of the heat stimulus regarded as painful were difficult to obtain in these patients, and have not been included in the study(2).

Sixteen of the 23 patients originally studied were retested during the 13-24 months' postoperative interval. Three of the 16 have been eliminated from the comparative data as they had only one preoperative test. The 13 patients included in this study had 2 tests before operation and 1 test at the following postoperative periods: 15-60 days, and 13-24 months. Ten of the patients were also studied during the 3-12 months' postoperative period. Eleven patients were diagnosed as schizophrenia—9 of the paranoid type and 2 of the hebephrenic type. One patient had a diagnosis of involutional melancholia. One patient, with reactive depression, was lobotomized for intractable pain. She was suffering from right facial pain along the maxillary distribution of the trigeminal nerve, which had been unrelieved by either alcohol injection or posterior root section of the fifth cranial nerve. The patients were operated upon by Dr. James L. Poppen. The operation was designed to transect the white matter in both hemispheres by an incision extending from the center of the trephine openings, located 3 cm. anterior to the coronal suture and 3 cm. lateral to the midline of the skull, down to the gray matter on the orbital surface of the frontal lobe, the transection occurring in a plane just in front of the tip of the anterior horn of the lateral ventricle.

Method

The modified Hardy-Wolff-Goodell pain threshold apparatus and the testing procedure used in these studies have been described elsewhere(1). The source of the heat stimulus was a 1,000-watt Mazda lamp. The light from this lamp was focused by

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2 lenses through an aperture 2.5 cm.² in area onto the mid-line of the forehead, which was blackened with India ink. Each exposure was kept constant at 3 seconds by a shutter operated by a telechron motor and the intensity varied uniformly by a wire rheostat. The amount of heat used was calibrated by a radiometer and expressed in units of gm. cal./sec./cm.² of skin surface. Each test consisted of from 10 to 14 exposures of the light. The intensities ranged from 0.189 gm. cal./sec./cm.², at which level the heat felt like a warm glow, to a maximum stimulus level of from 0.407 to 0.412 gm. cal./sec./cm.² Levels higher than these maximum values were not exceeded in order not to blister the skin. The 2 levels of heat causing motor withdrawal reaction that were measured were as follows: (1) the level causing a wince reaction noted as an initial contraction of the muscles at the outer canthus of the eye, and (2) the level causing the patient to pull his head away from the apparatus. Some patients took the maximum intensity of stimulus without showing any motor withdrawal reaction. In such instances their wince and pull-away levels were arbitrarily designated at 0.407 or 0.412 gm. cal./sec./cm.² An individual's wince level and pull-away level were determined as the mean of the sum of the lowest consistent levels at which the particular motor reaction took place, plus all inconsistent levels. Levels higher than the lowest consistent levels were excluded from the determinations.

One change has been made in handling the data in this report as compared to the study covering the first-year postoperative period (2). Four patients showed no motor withdrawal reaction either before or after lobotomy at the maximum stimulus levels. Their values were excluded from the determinations in the first study but have been included in these calculations.

Results

I. *Pull-Away Reaction.*—As shown in Fig. 1, the level of heat stimulus causing the patients to pull the head away from the apparatus has shown a definite tendency to return to the preoperative levels. Before lobotomy the patients pulled the head away at the same average values of 0.359 gm. cal./sec./cm.², for test 1 and 2. Fifteen to 60 days postoperative only 0.268 gm. cal./sec./cm.² was needed to cause them to move the head away from the apparatus. At 3-12 months after operation, the average pull-away reaction was obtained at 0.302 gm. cal./sec./cm.² At 13-24 months after lobotomy the mean pull-away reaction occurred at 0.331 gm. cal./sec./cm.² When considered individually only 2 of the 13 patients failed to show a distinct tendency to return to the preoperative levels during the second year postoperative period. While the differences in the mean levels were significantly lower at the 15-60 days postoperative period, the mean value of 0.331 gm. cal./sec./cm.² obtained at from 13 to 24 months after lobotomy was not significantly different from the mean of the 2 preoperative tests.

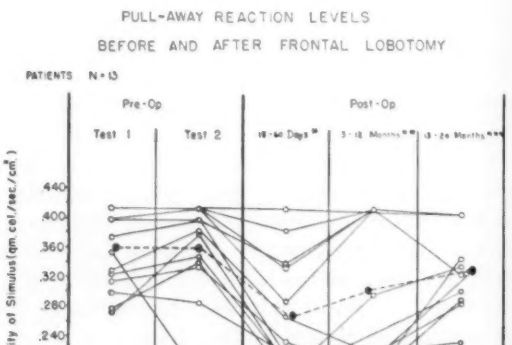

FIG. 1.—The chart shows the amount of heat stimulus causing the patients to pull the head away from the apparatus. The 13 patients were tested at all the periods indicated except for the 3-12 months' period when only 10 of the patients were studied. As shown by the figures at the bottom of the chart, the values at the 15-60 days' and 3-12 months' postoperative intervals were significantly lower than the preoperative tests. The values at the 13-24 months' postoperative period were not significantly different from the tests before operation. The chart indicates that the decreased tolerance to heat stimulus probably represented only a temporary change after lobotomy.

II. *Wince Reaction.*—Although the number of observations was smaller, the same tendency to show a recovery in the motor withdrawal reaction was seen for the wince reaction as for the pull-away reaction during

the second year after lobotomy. As shown in Fig. 2, before operation the same intensities of heat caused the patients to wince, the mean value for the 6 patients on test 1 being 0.371 and on test 2, 0.372 gm. cal./sec/cm.^{2} The mean value fell strikingly during the 15-60 day postoperative period to 0.291 gm. cal./sec./cm.^{2} The average level of 0.318 gm. cal./sec./cm.^{2} at the 3-12 month postoperative interval indicated a tendency of the patients to revert to their original wince levels. The mean wince reaction value of 0.370 gm. cal./sec./cm.^{2} for the second postoperative year was the same as the prelobotomy levels. While the number of tests was not sufficient for an adequate statistical comparison, the trend shows definitely that the decreased tolerance to heat discomfort observed over the first postoperative year represented only a temporary change after lobotomy.

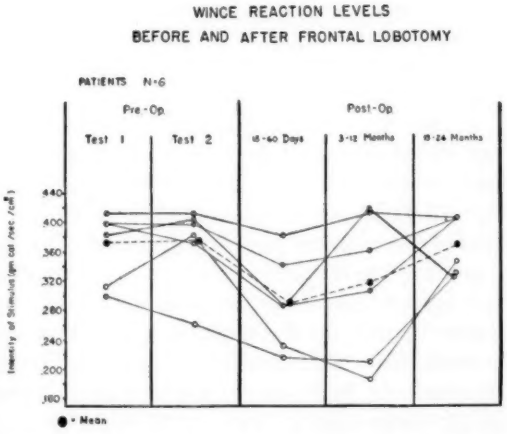

Fig. 2.—The mean levels of heat stimulus causing the patients to wince followed the trend of the pull-away reaction levels postoperatively. In view of the small number of observations, the values at the 15-60 days' and 3-12 months' postoperative periods were not significantly different from the values for the prelobotomy tests.

The one subject who illustrated most strikingly the exception to the trend after lobotomy was the patient operated upon for intractable right-sided facial pain. Throughout her 24-month postoperative course she has remained entirely free of pain. Before operation, gentle stroking of the right cheek appeared to cause extreme discomfort. This procedure had been repeated following each postoperative test. The patient remarked each time that stroking the right cheek was not uncomfortable nor did the maneuver cause her to flinch as she did before lobotomy. Fig. 3 shows that the level of heat

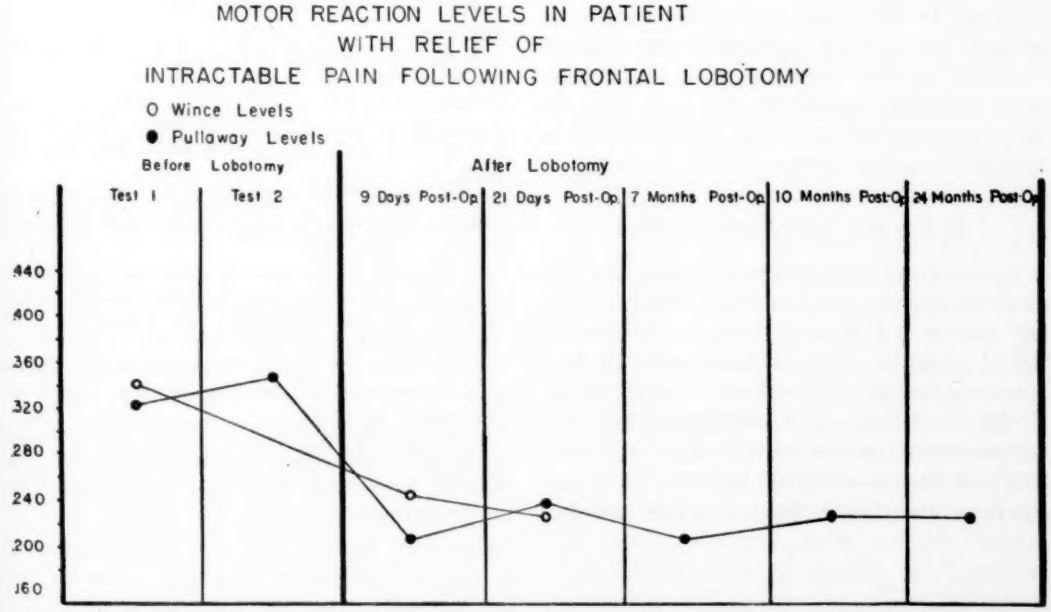

FIG. 3.—The chart shows that the patient who has remained free of right-sided facial pain after lobotomy has continued to show decreased tolerance to heat over a 2-year postoperative period. The low level of heat causing the patient to pull the head away from the apparatus made it impossible to assess the wince-reaction threshold on the 3 later post-operative tests.

causing her to pull her head away from the apparatus has remained significantly less than that during either of the preoperative tests. The wince-reaction thresholds were obtained only during the first preoperative test and the first two postoperative tests. The extremely low levels of heat that made her withdraw her head during the 3 subsequent tests made it impossible to assess adequately what her wince levels might have been at these later periods.

This patient was repeatedly asked why she pulled her head away from the apparatus. Her comment was always that the heat "hurts" and that she could not stand it. After being reassured that she could not possibly be burned by the heat stimulus and when asked to try to keep her head from moving, she still withdrew at the same levels of heat.

Sensitization of the skin over the forehead by the lobotomy scalp incision was considered a possible explanation of the changes in motor reaction noted after operation. Comparative studies on the dorsum of the hand and on the forehead revealed the same trend, indicating that the differences observed postoperatively were not due to the local condition of the skin(2).

The fact that lobotomy relieves intractable pain on the one hand and causes even temporarily the patient to tolerate heat discomfort less readily indicates that the mechanism involved in intractable pain may be of a different nature from that involved in withstanding our forms of discomfort.

Summary and Conclusions

1. A second-year follow-up study has been made of the intensity of heat stimulus causing motor withdrawal reaction in lobotomized patients. Measured amounts of heat were applied to the forehead by the Hardy-Wolff-Goodell pain threshold apparatus. The endpoints of motor withdrawal were the levels of heat causing the patient (1) to pull the head away from the apparatus and (2) to wince. Thirteen of the 23-patients originally tested were included in this study.

2. The results of the 13-24 months' follow-up test indicate that the decreased tolerance to heat discomfort noted in lobotomized patients during the first year after operation probably represented only a temporary change after lobotomy.

3. We have no adequate explanation either for the decreased tolerance to heat discomfort during the first postoperative year or for the tendency of the motor reaction pattern to return to the preoperative levels during the second postoperative year. A reasonable speculation could be that transection of the white matter in the frontal lobes removes a mechanism that inhibits withdrawal from discomfort. With the passage of time, some other mechanism in the central nervous system may take over such a rôle, which was previously the concern of the frontal lobes.

BIBLIOGRAPHY

1. Chapman, W. P., et al. Measurements related to pain in neurocirculatory asthenia, anxiety neurosis, or effort syndrome: Levels of heat stimulus perceived as painful and producing wince and withdrawal reactions. J. Clin. Invest., **25**: 890, 1946.

2. Chapman, W. P., et al. Measurements of heat stimulus producing motor withdrawal reaction in patients following frontal lobotomy. The Frontal Lobes. Res. Publ. Ass. Nerv. Ment. Dis., **27**: 754, 1948.

3. Dynes, J. B., and Poppen, J. L. Lobotomy for intractable pain. J. A. M. A., in press.

4. Falconer, M. A. Relief of intractable pain of organic origin by frontal lobotomy. The Frontal Lobes. Res. Publ. Ass. Nerv. Ment. Dis., **27**: 706, 1948.

5. Freeman, W., and Watts, J. W. Pain of organic disease relieved by prefrontal lobotomy. Lancet, **1**: 953, 1946.

6. Koskoff, Y. D., et al. The psychological effects of frontal lobotomy performed for the alleviation of pain. The Frontal Lobes: Res. Publ. Ass. Nerv. Ment. Dis., **27**: 723, 1948.

7. Rose, A. S. Some observations on lobotomized patients based on routine neurological examination. In press.

8. Watts, J. W., and Freeman, W. Frontal lobotomy in the treatment of unbearable pain. The Frontal Lobes. Res. Publ. Ass. Nerv. Ment. Dis., **27**: 715, 1948.

CORRESPONDENCE

PRACTICE OF ELECTROSHOCK THERAPY

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Dr. Douglas M. Kelley wrote a comprehensive review of my book, "Practical Lessons in Psychiatry," which appeared in the June, 1950, issue of the JOURNAL. His critique shows that he read and digested the material thoroughly. However, I must point out a serious misconstruction of the contents of the chapter on electrocoma therapy.

Dr. Kelley says, "While these chapters are excellent in themselves, they are definitely out of place in the present volume." The reason for this opinion, as given by Dr. Kelley, is, "There seems no doubt that the average general practitioner reading the book will assume that it indicates his potential ability to handle shock therapy."

Such a statement has no basis expressed or implied in the book. On the contrary, the detailed description of the procedure, from the selection of the psychotic patient to the technical phase of the treatment, is assigned as a major task of psychiatry. In contrast to Dr. Kelley's deduction, this is what the text actually states (page 165): "Merely possessing an electroshock machine does not assure results. There is needed an experienced psychiatrist who knows his patient, the dosage and course of the illness—and how best to employ electrocoma therapy along with psychotherapy."

On pages 172 and 173, clearly expressed in italics, is the following: "I would advise any psychiatrist who wants to use this method successfully to train with one who is thoroughly familiar with the apparatus, the pretreatment medication, the dosage, the timing. Merely procuring the apparatus and an instruction sheet is inadequate preparation in the use of a method whose potential for good is so great. Properly administered, electrocoma therapy can contribute tremendously towards recovery. Electrocoma therapy used in a haphazard fashion, minor reactions, incomplete series of treatments, neglect of after care will lead to a higher percentage of failures than need be."

The aim of this chapter was to provide a clear understanding for nurses, psychologists, and practitioners in a field where there has been considerable misunderstanding. How closely this aim was reached may be inferred from the following sentence from the review of my book in the *Southern Medical Journal* (May, 1950): "The section on electroshock therapy, with an introduction by Dr. Foster Kennedy, is the best yet seen by the reviewer."

JOSEPH L. FETTERMAN, M. D.
Cleveland, Ohio.

REPLY TO THE FOREGOING

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Dr. Fetterman has unfortunately misinterpreted the wording of my review insofar as my opinion naturally is my own and hardly would be expected to be expressed or implied in his book. The chapters on electroshock therapy, as the *Southern Medical Journal's* reviewer states and with which I have already agreed in the review, are excellent. As a matter of fact, it is this very excellence which made me feel them to be out of place in a volume specifically written for nonpsychiatrists. Warnings for psychiatrists are, of course, superfluous, unless Dr. Fetterman hoped some experts would read the book for other purposes than merely review. Since the book was not written for psychiatrists, however, Dr. Fetterman's unusually detailed discussion, going beyond merely clear understanding of method, must be purposeful in nature. Oddly enough it was the interpretation of a half-dozen of my colleagues who are general practitioners that he had intended this excellent and well-ordered chapter to provide information that they might perhaps use the method. Unfortunately, to these physicians the excellence of the information provided outweighed the warnings.

DOUGLAS M. KELLEY, M. D.,
Berkeley, Calif.

COMMENT

ALASKA MENTAL HEALTH SURVEY

A study of the mental health services of Alaska was conducted during August 1949 at the request of the Department of the Interior, the agency of Government responsible for the care of the "Alaska insane." The purposes of the study were (1) to determine, on the ground in Alaska, the methods of committing and treating mentally ill patients and the relation of these activities to other health activities and (2) to make recommendations for the improvement of mental health services in the Territory. The members of the Survey Committee were Dr. Winfred Overholser, Superintendent, Saint Elizabeths Hospital, Washington, D. C., Chairman; Dr. Dale C. Cameron, Assistant Director, National Institute of Mental Health, U. S. Public Health Service; Dr. Earl Albrecht, Territorial Commissioner of Health; Dr. James Googe, Medical Director, Alaska Native Service, Bureau of Indian Affairs; and Mr. M. W. Goding, Assistant Chief, Alaska Branch, Division of Territories and Island Possessions.

After visiting Morningside Hospital at Portland, Oregon, the contract hospital where the mentally ill of Alaska have been cared for since 1904, the survey committee covered a representative cross section of the Territory from Ketchikan on the south to Kotzebue, north of the Arctic Circle. In so doing, visits were made not only to the larger centers, Ketchikan, Juneau, Anchorage, and Fairbanks, but also to some of the more remote villages and outlying communities where the provision of psychiatric services and the problems of providing an adequate commitment procedure are much more difficult. Every opportunity was taken to discuss the mental health problems with practicing physicians, government and local officials, and other interested citizens. Their marked interest and helpful cooperation were most gratifying.

There is no mental health program worthy of the name in Alaska, though the public has become increasingly aware of the need for such a program and the Territorial Department of Health is endeavoring to recruit personnel to develop a basic program of education and limited early diagnostic and treatment services. There are no preventive activities of any sort, no mental health clinics, no hospitals equipped to offer inpatient treatment; in fact, many of the general hospitals of the Territory will not knowingly accept a mental patient for temporary detention, let alone treatment. Only one psychiatrist, practicing part-time, was to be found to serve the needs of over 100,000 people in an area one-fifth the size of the United States.

The present method of calling the existence of a person who is possibly mentally ill to the attention of the authorities, detaining, committing, and transporting him to Morningside Hospital in Portland, Oregon, is as follows: A citizen is required to file a written complaint charging that "X" is "an insane person at large" with the United States Commissioner who then orders the U. S. Marshal to take the alleged insane person into custody and detain him in jail until arrangements can be made for a trial. A jury of six is empaneled and if "X" is found "guilty" of being "an insane person at large" he is "committed." The patient is then transported to Morningside by the U. S. Marshal. This procedure is, to say the least, highly unsatisfactory and utterly out of line with present concepts and methods of psychiatric treatment. The Committee was astounded to discover that sick persons, especially those who are charges of the Government of the United States, are, in this age, placed in quarters as unsafe (fire trap), overcrowded, unsanitary, and generally demoralizing as the present building maintained as a Federal jail in Anchorage, the largest city in Alaska. The use of this fabulous obscenity as a place to house mental patients is nothing short of barbaric,

despite the effort of the U. S. Marshal and his staff to render decently humane treatment. It must also be said that this facility is fully as unsuitable for prisoners as it is for the mentally ill.

The Committee has forwarded recommendations to the Department of the Interior for the complete revamping of commitment procedures, the construction of hospital facilities for the care of short- and long-term patients in Alaska and, in collaboration with the Territorial Department of Health, the development of emergency treatment centers in most of the general hospitals in the Territory and the integration of these services with other medical activities in Alaska.

DALE C. CAMERON, M. D.,

CALIFORNIA PLANS RESEARCH ON SEX CRIMES

The California Legislature has recently passed an act "to provide for scientific research into the problem of sex crimes, including the causes and cure of sex deviation, and making an appropriation." This bill has been signed by the Governor and it was anticipated that research would be started on July 1st of this year. The bill reads as follows:

SECTION 1. The Department of Mental Hygiene, acting through the Superintendent of The Langley Porter Clinic, shall plan, conduct, and cause to be conducted scientific research into the causes and cures of sexual deviation, including deviations conducive to sex crimes against children, and the causes and cures of homosexuality, and into methods of identifying potential sex offenders.

SECTION 2. Upon the recommendation of the Superintendent of The Langley Porter Clinic, the Department of Mental Hygiene may enter into contracts with the Regents of the University of California for the conduct, by either for the others, of all or any portion of the research provided for in this act.

SECTION 3. It shall be the duty of each state agency to cooperate with the Superintendent of The Langley Porter Clinic, or with the University of California, as the case may be, to the fullest extent that the facilities of such state agency will permit without interfering with the carrying out of the primary purposes and functions of such state agency.

SECTION 4. The Superintendent of The Langley Porter Clinic shall make a written and detailed report of the activities and studies under this act and his findings and recommendations relating thereto and file the same with the Governor and the Legislature not later than March 1, 1951. In this report said superintendent shall outline such further research program as he deems it desirable to undertake and shall outline the more promising avenues of research. Said superintendent may include in such report such bibliography of materials for study as he deems appropriate.

SECTION 5. The Department of Mental Hygiene with the approval of the Director of Finance may accept gifts or grants from any source for the accomplishment of the objects and purposes of this act. The provisions of Section 16302 of the Government Code do not apply to such gifts or grants and the money so received shall be expended to carry out the purposes of this act, subject to any limitation contained in such gift or grant.

SECTION 6. There is hereby appropriated out of the General Fund in the State Treasury one hundred thousand dollars ($100,000) to be expended by the Department of Mental Hygiene in carrying out the provisions of this act, not more than fifty thousand dollars ($50,000) of which shall be spent in any one fiscal year.

K. M. B.

NEWS AND NOTES

DR. GOLDWIN HOWLAND DIES.—A pioneer in neurology and psychiatry in Toronto, Dr. Goldwin Howland died in that city shortly after passing his 75th birthday in July 1950.

Dr. Howland was a veteran of World War I, a Fellow of the Royal College of Physicians (London), a charter member of the Royal College of Physicians and Surgeons of Canada, and for many years head of the division of neurology in the University of Toronto medical faculty.

A major contribution of Dr. Howland to remedial medicine was his leadership in occupational therapy in Canada. The first university course in occupational therapy (University of Toronto 1926) was planned by him. In the same year the Canadian Association of Occupational Therapy was founded, with Dr. Howland as first president. The fact that every year he was reelected president until he insisted upon retiring in 1948 is sufficient evidence of the esteem in which he was held and of the appreciation of his labours as the recognized father of organized occupational therapy in Canada.

A further recognition was the establishment in 1945 of the Goldwin Howland Scholarship Fund with an annual award to enable graduate therapists to take special courses outside the Dominion. This fund was created by voluntary subscriptions of occupational therapists and is perpetuated by allocation of a portion of the annual dues.

Not least among the means to promote occupational therapy were Dr. Howland's many anonymous donations where help was needed, in both local and national fields. He would never permit these gifts to be publicised in any way and would virtually extract a vow of secrecy from the few persons concerned in handling them. It is appropriate now, however, that these personal acts of generosity should be known.

Since World War I Dr. Howland has been the vital driving force behind all developments in every field of occupational therapy in Canada.

He had been a Fellow of The American Psychiatric Association since 1931, the year the annual meeting was held in Toronto, but had relinquished his membership within the last few years.

THE AMERICAN HOSPITAL OF PARIS.—The American Hospital, which has at various times in its career been taken over by the American, French, and German armies, is now fully restored for meeting civilian needs. Dr. Beckman J. Delatour, associate professor of medicine at New York University since 1944, assumed on July 1 his duties as clinical director and director of medical services.

Dr. C. Charles Burlingame, chairman of the hospital's advisory board in America, stated: "The appointment of an outstanding man like Dr. Delatour is significant of the aggressive program of scientific development being undertaken in that pioneer American institution. Mr. Nelson Dean Jay, who has so ably headed the Board of Governors in restoring the hospital, has declined re-election, and Mr. John B. Robinson succeeds as President."

The American Hospital of Paris, located in suburban Neuilly-sur-Seine, is in a sense the representative abroad of American medical science and treatment. Its services are available to any American citizen requiring care, regardless of ability to pay. Foreign paying patients are cared for when private-room facilities permit.

The million-dollar plant now occupied by the American Hospital was completed in 1926 as a memorial to men and women who served in the first World War. Today the hospital has 153 beds and 20 bassinets and an outpatient service. A limited number of appointments to residency and internship are made by the advisory board in America.

CONDITIONS OF A WORLD SOCIETY.—In an article appearing in the June 1950 Christian Register (Unitarian), Dr. Quincy Wright, leading author in this issue of the

JOURNAL, discusses the possibilities of making the United Nations a more effective organization for enforcing world order. He sums up the desirable conditions for a world society as follows:

> The foregoing discussion suggests that a culture capable of becoming universal under present conditions should be ambiguous in ultimate standards, precise in immediate procedures, scientific in methods, and tolerant of the diverse opinions and standards of its individuals and groups. Such a culture implies concern for humanity rather than for particular groups, concern for freedom rather than for conformity, reliance upon observation rather than upon intuition, and acceptance of relativity rather than of dogma.

THE CIBA FOUNDATION.— This Foundation was established in England in June 1949, by Ciba Limited, a Swiss company, for the promotion of international cooperation in medical and chemical research. Four international symposia or conferences have been held, to which American participation has made a notable contribution. Trustees of the new Foundation are: the Rt. Hon. Lord Beveridge, the Rt. Hon. Lord Horder, Professor E. D. Adrian, and Mr. Raymond Needham. The Foundation maintains a center with libraries, reception rooms, etc., at 41 Portland Place, London W1.

WORLD HEALTH ORGANIZATION REPORTS AVAILABLE.—Two recent publications of WHO, technical reports Nos. 9 and 21, will be of interest to psychiatrists generally. One pamphlet, No. 9, which reports on the first session of the expert committee on mental health at Geneva in August and September 1949, is a survey of mental health problems. It includes the recommendations of the expert committee to the World Health Organization, and these stress particularly the importance of prevention.

The second pamphlet, No. 21, is a report of the second session in January 1950, at Geneva, of the expert committee on drugs liable to produce addiction. At this session the committee considered the nature of drug addiction and made certain recommendations concerning various specific drugs.

These reports are available from the Columbia University Press International Documents Service, 2960 Broadway, New York 27; in Canada through the Ryerson Press, 299 Queen St. West, Toronto; and in England from H. M. Stationery Office, P. O. Box 569, Landon S.E.1.

INSTITUTE OF LIVING ACQUIRES RARE BOOKS.—A collection of 350 rare books in the psychiatric field amassed by the late Dr. Hubert Norman, British psychiatrist, has recently been acquired by the Institute of Living, Hartford, Conn. These books, many of them first editions of famous works, date back to the late 18th and early 19th centuries. They will be housed in the medical library of the Burlingame Research Laboratory, which already contains 6,500 volumes aside from the Smith Ely Jelliffe collection of 10,000 and many thousand reprints. These 350 rare books will be available to members of the medical profession, scholars, and other qualified individuals.

JOURNAL OF SOCIAL ISSUES.—A recent issue of this journal, Vol. 5, No. 4, 1949, is devoted to "Social Values and Personality Development," and the authors are Max L. Hutt and Daniel R. Miller of the University of Michigan, Psychology Department.

The Journal of Social Issues is published quarterly, sponsored by the Society for the Psychological Study of Social Issues, a Division of the American Psychological Association. Address of the publisher is the Association Press, 291 Broadway, New York 7, N. Y.; subscription rate is $3 per year.

VETERANS HOSPITAL, NORTHPORT, L. I.— Dr. Harry C. Solomon, professor of psychiatry at Harvard University and medical director of the Boston Psychopathic Hospital, was guest speaker at the VA Hospital in Northport, L. I., N. Y., July 18, 1950. Dr. Solomon discussed significant aspects of the care and treatment of acute and chronic psychotic patients, including reports on the newer therapies.

Physicians from the surrounding New York state hospitals, including Kings Park, Central Islip, Pilgrim, and Creedmoor, attended the meeting.

PIEDMONT PSYCHIATRIC CLINIC.—The Piedmont Psychiatric Foundation, chartered under the laws of the State of California in 1948 as a nonprofit corporation for the support of psychiatric activities, has arranged with the Piedmont Psychiatric Clinic of Oakland to provide free or part-paid outpatient services for adults and children.

The address of the clinic is 6254 Claremont Ave., Oakland 18, Calif. The new service began July 5, 1950.

AMERICAN NEUROLOGICAL ASSOCIATION. At the seventy-fifth annual meeting of the American Neurological Association held in Atlantic City, N. J., June 12-14, 1950, the following officers were elected for the year 1950-1951: president, Dr. Wilder Penfield; president-elect, Dr. S. Bernard Wortis; first vice-president, Dr. Roland P. Mackay; second vice-president, Dr. Donald MacPherson; secretary-treasurer, Dr. H. Houston Merritt; assistant secretary, Dr. Charles Rupp.

DR. KILPATRICK NEW DIRECTOR OF HUDSON RIVER STATE HOSPITAL.—On August 1, 1950, Dr. O. A. Kilpatrick became senior director of the Hudson River State Hospital, Poughkeepsie, N. Y. Dr. Kilpatrick has been in the state hospital system since 1930, having served at Marcy, Willard, Rockland, and Rochester state hospitals, and he represented the Department of Mental Hygiene as medical inspector in 1946 and 1947, following wartime service as chief of the neuropsychiatric division of Walter Reed General Hospital, Washington, D. C.

NARCOTICS ANONYMOUS.—Several months ago a discharged patient from the U.S.P.H.S. Hospital at Lexington, Ky., was instrumental in organizing in New York City a group of narcotic habit patients after the pattern of and with the cooperation of Alcoholics Anonymous. This form of group therapy originated in 1947 among patients at the Kentucky hospital where both Federal prisoners and voluntary patients are under treatment for drug habits.

The initial chapter in New York City started with 16 members and its membership is expanding. For the time being the meetings are held twice weekly at the Salvation Army headquarters, 535 W. 48th St.

AMERICAN ASSOCIATION OF UNIVERSITY WOMEN, ANNUAL AWARD.—The 1950 Achievement Award of $2,500 has been presented to Dr. Elizabeth C. Crosby, professor of anatomy, University of Michigan, for her work on the cerebral cortex and midbrain in the primates. Dr. Crosby has an international reputation for her brain research and has conducted courses at the University of Aberdeen and the University of Puerto Rico and has also been associated with the University of London and the Institute for Brain Research at Amsterdam.

SOUTHEASTERN SOCIETY OF NEUROLOGY AND PSYCHIATRY.—This Society has been provisionally accepted as an affiliate society of the A.P.A. pending the adoption of a policy regarding new affiliate societies.

Dr. Bartemeier calls attention to the fact that this item was inadvertently omitted in the report of the Detroit meeting that appeared in the July issue of the JOURNAL.

ANNOUNCEMENT BY PROGRAM COMMITTEE

Officers and members of the different Sections have at times been critical about the scheduling of their Section meeting at the Annual Meeting. They have requested that their Section meet on the first or second day.

The Association now has six different Sections. In order to get in meetings of all these Sections, and to give time for reading the many papers offered and accepted, the Association now has to have five days of meetings. Therefore, it is not possible to have all the Sections meet within the first two or even three days. Similarly all the papers submitted cannot be read during the first three days.

The Program Committee has adopted the policy of rotating the Sections so that one Section which has met early one year may expect a later time in the week at the next meeting.

The Program Committee gives this infor-

mation in the interest of better feelings and better understanding by the members of the difficulties involved and of effort being made to work this out in a fair manner.

REQUEST FROM NOMINATING COMMITTEE

The Nominating Committee would be glad to receive from Members and Fellows of all classes suggestions for nominations for the offices to be filled at the elections at the next meeting. The offices to be filled are: (1) President-Elect, (2) Secretary, (3) Treasurer, (4) Three Councillors, and (5) One Auditor.

It will be helpful if such suggestions can be in the hands of any of the members of the Committee before October 25th.

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THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.

The following were certified at San Francisco, Calif., June, 1950.

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MAJOR ENGLISH-LANGUAGE PERIODICALS IN THE FIELD OF PSYCHIATRY[1]

1 American Journal of Mental Deficiency
372 Broadway, Albany, N. Y.

2 American Journal of Orthopsychiatry
303 Lexington Ave., New York 16, N. Y.

3 American Journal of Psychiatry
113 St. Clair Ave. West, Toronto 5, Canada

4 American Journal of Psychology
Box 446, Palo Alto, Calif.

5 American Journal of Psychotherapy
16 West 77 Street, New York 24, N. Y.

6 (The) American Psychologist
1515 Massachusetts Ave. N. W., Washington 5, D. C.

7 Archives of Neurology and Psychiatry
416 North Bedford Dr., Beverly Hills, Calif.

8 Brain
11 Wimpole Street, London, W. 1, England

9 British Journal of Inebriety
200 Euston Rd., London, NW. 1, England

10 British Journal of Medical Psychology
200 Euston Rd., London, NW. 1, England

11 British Journal of Social Medicine
British Med. Assn., Tavistock Sq., London, W. C. 1, England

12 Bulletin of the Los Angeles Neurological Society
1801 New Jersey St., Los Angeles 33, Calif.

13 Bulletin of the Menninger Clinic
3617 W. Sixth Ave., Topeka, Kansas

14 Digest of Neurology & Psychiatry
200 Retreat Ave., Hartford, Conn.

15 Diseases of the Nervous System
Univ. of Texas, 800 Ave. B, Galveston, Texas

16 Excerpta Medica (English). Section VIII
111 Kalver Straat, Amsterdam, Netherlands

17 Human Relations
2 Beaumont Street, London, W. 1, England

18 International Journal of Psychoanalysis
96 Gloucester Place, London, W. 1, England

19 Journal of Abnormal and Social Psychology
374 Broadway, Albany, N. Y.

20 Journal of Applied Psychology
1515 Massachusetts Ave., N. W., Washington 5, D. C.

21 Journal of Child Psychiatry
30 West 58 St., New York 19, N. Y.

22 Journal of Clinical Psychopathology
1708 Massachusetts Ave., N. W., Washington 6, D. C.

23 Journal of Comparative Neurology
Wistar Institute. 3600 Woodland Ave., Philadelphia 4, Penna.

24 Journal of Comparative Psychology
Williams & Wilkins, Baltimore 2, Md.

25 Journal of Consulting Psychology
525 West 120 St., New York 27, N. Y.

26 Journal of Educational Psychology
10 East Centre St., Baltimore 2, Md.

27 Journal of Electroencephalography & Neurophysiology
Massachusetts Gen'l Hosp., Boston 14, Mass.

28 Journal of Experimental Psychology
1227 Nineteenth St., N. W., Washington 6, D. C.

29 Journal of Genetic Psychology
2 Commercial Street, Provincetown, Mass.

30 Journal of Mental Science
104 Gloucester Place, London, W. 1, England

31 Journal of Nervous and Mental Diseases
70 Pine Street, New York 5, N. Y.

32 Journal of Neurology and Psychiatry
British Medical Assn. Tavistock Sq., London WC. 1, England

33 Journal of Neuropathology and Neurology
912 South Wood Ave., Chicago 12, Ill.

34 Journal of Neurophysiology
301 East Lawrence Ave., Springfield, Ill.

35 Journal of Neurosurgery
301 East Lawrence Ave., Springfield, Ill.

36 Journal of Parapsychology
Duke University, Durham, No. Carolina

37 Journal of Personality
Duke University, Durham, No. Carolina

38 Journal of Psychology
2 Commercial St., Provincetown, Mass.

39 Journal of Social Hygiene
50 West 50 Street, New York, N. Y.

40 Journal of Speech & Hearing Disorders
University of Iowa, Iowa City, Iowa

41 Mental Health
24 Buckingham Palace Rd., London, SW. 1, England

42 Mental Hygiene
1790 Broadway, New York 19, N Y.

42 The Nervous Child
Williams & Wilkins, Baltimore 2, Md.

44 (The) Psychiatric Aide
1520 Race St., Philadelphia 2, Penna.

45 Psychiatric Quarterly
Utica State Hospital, Utica, N. Y.

46 Psychiatry
1711 Rhode Island Ave., N. W., Washington 6, D. C.

47 Psychoanalytic Quarterly
374 Broadway, Albany, N. Y.

48 Psychoanalytic Review
70 Pine Street, New York 5, N. Y.

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[1] This list has been kindly submitted by Dr. Henry A. Davidson, who does not guarantee its completeness. Corrections or supplementary information will be appreciated.

The address in some cases may be the office of the editor, in others the place of publication, and in still others the location of the sponsoring organization.

49 Psychological Abstracts
University of Illinois, Urbana, Ill.

50 Psychological Bulletin
1515 Massachusetts Ave., N. W., Washington 5, D. C.

51 Psychological Review
1515 Massachusetts Ave., N. W., Washington 5, D. C.

52 Psychometrika
23 W. Colorado Ave., Colorado Springs, Col.

53 Psychosomatic Medicine
714 Madison Ave., New York 21, N. Y.

54 Quarterly Journal of Speech
Wayne University, Detroit, Mich.

55 Quarterly Journal of Studies in Alcohol
52 Hillhouse Ave., New Haven, Conn.

56 Quarterly Review of Psychiatry & Neurology
1720 M Street, N. W., Washington, D. C.

57 Sociometry
Beacon House, Beacon, N. Y.

BOOK REVIEWS

MENTAL HYGIENE IN PUBLIC HEALTH. By *Paul V. Lemkau, M. D.* (New York: McGraw-Hill Book Company, Inc., 1949.)

Dr. Lemkau has had the advantages of some 14 years' experience in teaching, for the preparation of a text on the possible relations of mental hygiene to the practices of public health. The book is suitable for study by all students of medicine and by students as well in other lines of endeavor. It should be stimulating and useful to all the personnel engaged in public health work. It is understandable and instructive for any reader interested in an introduction to the fundamentals of mental hygiene.

Dr. Lemkau's writing shows great care in the choice of language to present his thinking unambiguously, precisely, and soundly. The content is well organized throughout and covers the fundamentals of mental hygiene from infancy through old age. Summaries in recapitulation occur at appropriate intervals. Each chapter is followed by lists of source material that may serve as reading references. An appendix gives the health officer a sketch of types of mental illness for a minimal understanding in connection with, for example, his participation in the function of commitment procedure. Finally, a chapter on visual aids provides classified lists of motion picture films appropriate to the subject.

Dr. Lemkau has contributed a sound and useful book, which presents primary understanding of the principles and applications of mental hygiene, from which the reader may go to other reading, if he wishes to obtain more specialized and intricate elaboration.

GLENN MYERS, M. D.,
Compton, Calif.

MALE AND FEMALE. A STUDY OF THE SEXES IN A CHANGING WORLD. By *Margaret Mead.* (New York: William Morrow & Co., 1949.)

This book is not a treatise. It is a series of lessons in human relationships: an unraveling and reweaving of parts of the fabrics of human cultures, and not a statistical excision of isolated threads to construct unreal stereotypes. The general theses are not unexpected: that the sex differences we live by are cultural elaborations made with scant regard for our bodies; and that in America we could honour and use with profit the great variety of personalities of each sex that our culture now standardizes with wasteful friction.

The first thesis develops from comparisons between the bringing up of boys and of girls among the unhurried Samoans, the elaborate Balinese, the commercial and puritan Manus, and 4 New Guinea societies that stress first long suckling and then men's-house toughness and show in strikingly different ways male envy of the female rôle (the swaggering Iatmul, henpecked Tchambuli, angry Mundugumor, and permissive Arapesh). Behaviour between children and their elders is analysed in symmetrical, complementary, or reciprocal modes. Such psychobiological determiners of sex behaviour as the mammalian mother-infant relationship, the dramatic life-changes yet continuous mating readiness of the human female, and the great range of constitutional variants in both sexes are shown to be unpredictably felt and used by different cultures. In such diverse problems as homosexuality, female orgasm related to erotic zones, or population pressure these biological factors are so culturally channeled that no human behaviour can be labeled "natural." Dr. Mead concludes, "Our humanity depends upon our relative infertility, upon the long period of human gestation and dependency possible only where there are few children, who can be reared long and lovingly. It depends upon the presence of warm human responses in both sexes that are not tied tight to a reproductive cycle in the female. But to . . . discipline this . . . requires more knowledge and more finely wrought pattern of human relationships than mankind has yet conceived."

The second thesis describes a vicious circle: that the identical education, teasing dating game, and showy job race between American males and females destroy their fully complementary efforts to create the democratic ideal way of life. This shows in the contradictory attitudes toward marriage, divorce, home-making with its lost prestige, mechanical baby-rearing, and being a "success" in our heterogeneous and fast-changing society.

All of this has sharp interest for patient as well as for psychiatrist. But for the physician by far the most vital part of the book is Appendix II, on the ethics of insight-giving. This statement of principles explains why clinical or dramatic topics like prostitution, pseudocyesis, or alcoholism are largely omitted, and partly accounts for occasional obscure word-frescoes (as in the chapter "Our Complex American Culture"). But Dr. Mead's whole approach remains broad in scope, indirect, without oversimplifications, and uses the device of emphasis by restraint rather than by heavy adjectives, new jargon-words, or arrowed diagrams. There are full bibliographies.

J. LAWRENCE ANGEL, PH. D.,
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Jefferson Medical College,
Philadelphia, Pa.

CURRENT THERAPY, 1949. THE LATEST APPROVED METHODS OF TREATMENT FOR PRACTICING PHYSICIANS. Edited by *Howard F. Conn.* (Philadelphia: W. B. Saunders Co., 1949.)

This volume, quarto in size, of 672 pages condenses in a remarkably concise fashion the modern treatment of a very large number of maladies. The consulting editors are all distinguished physicians. The list of contributors is very large but excellently chosen and numbers 243. The 14 sections of the book are: (1) Infectious Diseases, (2) Diseases of the Digestive System, (3) Diseases of Metabolism and Nutrition, (4) Diseases of the Endocrine System, (5) Diseases of the Genitourinary Tract, (6) The Venereal Diseases, (7) Diseases of Allergy, (8) Diseases of the Skin, (9) Diseases of the Respiratory System, (10) Diseases of the Cardio-vascular System, (11) Diseases of the Blood and Spleen, (12) Diseases of the Nervous System, (13) Obstetrical and Gynecological Conditions, and (14) Diseases Due to Physical and Chemical Agents.

The reviewer is inclined to think that greater space might have been allotted to diseases of the endocrine system and to the section on diseases of the respiratory system. The section on diabetes mellitus is particularly well done by leaders in the field.

The volume is devoid of references to the literature. This, in the reviewer's opinion, is an important deficiency. Obviously, in a volume of this design it would be impossible to give full discussion of the treatment of a large number of diseases; however, the contributors, in the main, have made excellent selections of their therapeutic recommendations.

The stated purpose of the editor and publisher to furnish the busy practitioner not only with the *latest* method of treatment of a particular condition but a method *endorsed* and currently *used* by a competent authority seems to have been fulfilled. Time will tell whether the changes in therapy in all fields of medicine will be rapid enough to justify an annual volume of this nature.

JAMES J. WARING, M. D.,
University of Colorado.

1949 YEAR BOOK OF NEUROLOGY, PSYCHIATRY AND NEUROSURGERY. Edited by *Roland P. Mackay, M.D.* (neurology), *Nolan D. C. Lewis, M.D.* (psychiatry), *Percival Bailey, M.D.* (neurosurgery). (Chicago; The Year Book Publishers, 1950. Price $5.00.)

The Year Book series and this century began together, with Hugh T. Patrick, assisted by Charles L. Mix, producing the first Year Book of Nervous and Mental Disease.

Changes in the editorial board have perforce occurred from time to time. This year finds a new name at the head of the section on neurology, so ably conducted by Hans H. Reese since 1934, with the collaboration of Dr. Mabel G. Masten since 1944. Dr. Mackay, who now takes over, is professor of neurology at the University of Illinois and attending neuropsychiatrist, St. Luke's Hospital, Chicago. He has had the assistance of Dr. Oscar Sugar in the abstracting of the material.

In introducing his section Dr. Mackay states something of his credo, in particular as to the mutual relations of the several fields represented in this book. He is "jealous lest splinter movements veer too far from our biologic home, and become lost in mysticism and obscurantism. Useful as the intuitive flash may be in the explanation of human behavior, such explanations must come through the fires of verification purged of dross and irrelevancy. The neurologist can render an important service to psychiatry in this purging process, in that he can apply to the seductive and facile formulations of the dynamic psychiatrist a seasoned skepticism based on the critical standards of physiologic fact. Similarly, the psychiatrist, as a humanist, can inspire the dead bones of a sometimes monastic neurology, and teach its devotees that there is more to life than the columns of Clarke and the areas of Brodmann."

Mackay directs attention to the physiologic subjects reviewed, especially neurochemistry, "a field in which neurology confidently expects revolutionary developments in the near future."

A special chapter on therapeutic methods includes half a dozen reports on the newer treatment procedures in Parkinsonism.

Nolan Lewis observes that the greatly increased attention of a number of psychiatrists to social relations and social ills during recent years has caused laymen generally to misconceive this discipline as concerned only with these aspects of the subject, overlooking the fact "that psychiatry is also a biologic science dealing with basic physiologic, biochemical and pathological processes in the brain and other bodily organs which underlie human mental life in its normal and abnormal expressions. Moreover, psychiatry is, in some respects, a physical science in that some of its technics measure how various physical stimuli are seen, heard or felt by a person, and how he functions in terms of energy phenomena."

Percival Bailey again calls attention to the serious disadvantage of the civilian paraplegic patient, "doomed to an early death from pressure sores and infection," as compared with the veteran paraplegic for whom special services in the veterans' hospitals provide the best of care. He expresses the hope "that the medical profession will aid the movement to seek legislation permitting the admission of civilian paraplegics to veterans' hospitals."

Bailey is critical of the extensive use of frontal lobotomy except in the case of a legally committed, chronic, disturbed, and destructive patient, considered incurable after all other means of treatment have failed. He censures surgeons who perform lobotomy in other cases. With a *soupçon* of sarcasm he remarks that some neurosurgeons "were thankful for the icepick method which threw back the responsibility on the psychiatrist where

it belonged." In another place (p. 542) he states: "The transorbital method violates all surgical instincts."

For the localization of brain tumors Bailey considers ventriculography or arteriography much more useful than electroencephalography.

This well-indexed 668-page volume, about equally divided among the three subjects, does not assume to be a complete survey of the literature. It does, however, present a representative selection of the important studies and reports of the year and affords an excellent review of progress in the fields covered.

C. B. F.

INTRODUCTION TO THE SZONDI TEST. By *Susan Deri.* (New York: Grune and Stratton, 1949.)

This important book appears opportunely, as the Szondi test is arousing increasing interest among American clinicians, most of whom will probably not work their way through Dr. Szondi's two volumes in German. Mrs. Deri is eminently qualified to present the test to American readers, having worked for 4 years with its originator from the beginning of his investigations. Szondi's foreword makes it clear that he looks upon her as much more than an interpreter of his work, but she can at least be considered "approved" on that score. The book is clearly an attempt to teach clinicians how to *use* the test, and not in any sense a study of its validity or an effort to produce conviction about the latter. She says ".... acceptance of practically any of my statements about the .... constellations is left to the good-will of the reader" (p. xi). This remark will strike most American psychologists as rather odd, unless the purpose of the book is kept in mind. The treatment is detailed and concrete, beginning with administration and recording, proceeding to a discussion of the general interpretive principles, followed by separate chapters on each of the 4 vectors, and concluding with a section on syndromes and case illustrations. Careful study along with constant clinical use should enable anyone with general dynamic sophistication to interpret Szondi protocols, without training by an expert. The cautions against a naive, atomistic application, and against the direct translation of the nosologic rubrics used into descriptive psychiatric diagnoses, should leave no excuse for such mistakes. Objective criteria for the major quantifying terms, *e.g.*, "positive," "ambivalent," "open" are presented. It is clearly stated that direct inferences to overt behavior are not permissible. Treatment of alternative behavioral consequences and delicate shades of interpretation is often detailed, and the *kinds* of behavior likely to flow from a given dynamic interplay are usually suggested.

On the negative side, it is dangerous to speak pending satisfactory validity studies. There is a good deal of the "now-you-see-it-now-you-don't" type of discussion, in which the interpretations are loaded with enough qualification and references to the "rest of the pattern" so that we approach empirical emptiness. Although an isomorphism with the psychoanalytic vocabulary is denied, the constant use of it with subtly altered meanings produces a certain vagueness. In the attempt to get across the "feel" of a personality, enough words are used so that the picture becomes uncomfortably general. There is some statistical-psychometric naïveté (or else careless formulation). For example, we are told that ". . . . these changes always imply *some* change in the subject's attitude toward a particular drive" (p. 40). Here we see no apparent recognition of the existence of "uniqueness" in the factor-analytic sense—each picture is free of any contribution from specificity or error. Again, the question is not raised of how much of the temporal shifting found in schizophrenics could be attributable simply to the variability found in almost any kind of repeated performance obtained from these patients. Again, the threshold value for the various pictures is not discussed; it is apparently assumed that each picture is located at the same "difficulty" level on its own factor, and that no other variables produce differences in its stimulus properties. Hence, we are asked to accept differences among picture sets (absolute values) as confirmatory of the theory, *e.g.*, ". . . . minus *s* is not very frequent because it implies ability to sublimate aggression which is not common. . . ." (p. 77), or "the frequency of minus *p* in the general population . . . . is much higher than that of plus *p* . . . . this would mean that most people act according to their emotional needs . . . ." (p. 179). In general, all responses and shifts in responses are attributed to real changes in the named factors, as if perfect validity and factorial purity were established. The factor matrix of the Szondi must be unique among all psychological tests ever built, if this is true.

Finally, even though it is unfair to criticize a book for not achieving aims explicitly repudiated by the author, it is perhaps fair to ask why *no* systematic validity data are presented? This reviewer would gladly have exchanged Chapter III, on "factorial association," for a section of similar length presenting some validation material. After all, the book is not easy to read, and will be a lot of work to really master. Surely the reader is entitled to a few pages devoted to establishing validity, before taking on such a task. It is not a question of his lacking "good-will," since the best will in the world *could* not convince the scientific clinician on the basis of this book. Should we be asked to accept ". . . . proving it pragmatically by the use of the test . . ." (p. ix) or ". . . . the increasing demands for Szondi reports . . . ." (p. xi) as substitutes for validation studies, to the point of embarking on a learning task which will only *then* be able to tell us, from our own experience with it, whether we spent our time well or not? I do not think so.

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SCHICKSALSANALYSE. ERSTES BUCH, WAHL IN LIEBE, FREUNDSCHAFT, BERUF, KRANKHEIT UND TOD. (Fate-Analysis. First Book, Choice in Love, Friendship, Vocation, Disease, and Death.) Second, revised edition. By *L. Szondi.* (Benno Schwabe & Co., Verlag, Basel, 1948.)

This book is a presentation of the theory and method of research of what the author calls "fate-analysis." It contains genealogies of a large number of individuals intended to demonstrate the thesis that an individual's choices in matters of love, friendship, vocation, disease, and death are genetically determined. The term "fate-analysis" derives from definition of fate as "—the force exerted by hidden ancestors on choice in love, friendship, vocation, disease, and death." Further, fate-analysis is described as the "genealogy of the unconscious." The author explains, however, that for the present fate-analysis is limited to but a small part of total fate, namely, that of the drives of the individual. Total fate is said to have two other components: mental fate and social fate. The total fate of an individual is simply life.

Szondi considers fate-analysis to be one of the 3 chief methods of depth psychology, the other 2 being psychoanalysis and the complex psychology of Jung. He does not consider it to be an independent depth psychology based on heredo-biological foundations. It is an independent system only insofar as it is a specific method of research.

The basic ideas of fate-analysis are presented under the heading, "The Gene Theory of Object Choice." The paternal and maternal genes are portrayed as engaging in a primordial battle to settle which shall fashion the phenotype (manifest characteristics) of the new individual. The dominant genes represent the strongest, victorious genes in this battle. The displaced recessive genes are considered to be latent but not out of the picture. Quite to the contrary, the latent genes are postulated to operate in an exceedingly dynamic way. When the gene is present in only a unit dose, *i. e.*, in a heterozygotic state, it is assumed to operate "genotropically," that is, to guide or influence the choices an individual makes in the course of his life. The direction of these choices, moreover, is said to correspond to the original genotype hereditary picture.

Szondi's chief assumption is that the latent recessive gene influences the choices an individual makes. This postulated influence or force is called "genotropism" of which there are 5 types: libido-genotropism, which determines choice of mate; idealo-genotropism, which determines choice of friends and ideals; opero-genotropism, which determines choice of vocation; morbo-genotropism, which determines choice of illness; and thanato-genotropism, which determines choice of mode of death.

The force of libido-genotropism is said to draw persons together who have similar genes. An example is that of a man and a woman who marry, whose hearing is intact but who both have forebears who were deaf. The recessive genes for defective hearing that the man and woman carry are presumed to have drawn them together through influence of the unconscious of each of the individuals.

In the further development of the theory of fate-analysis the assumption is made that specific drive-genes exist that function as the sources of drive-determined strivings and needs. The specificity of the drive-gene determines the quality of the various drive-needs. On the basis of the organization of drives Szondi has constructed a comprehensive scheme by which an individual may be classified provided his fate and the fate of his forebears concerning love, friendship, vocation, disease, and death can be ascertained. Investigation along these lines, which Szondi calls "genotropic familial research," is the subject matter of this book. Many of the genealogies are highly entertaining. One cannot help being intrigued by the revelation that (to paraphrase Szondi liberally) surgeons spring from a long line of butchers, woodchoppers, and stonecutters, while psychiatrists hail from schizophrenic stock. The book does not, however, provide convincing evidence to support this highly speculative genetic theory.

Fancy is stirred by Szondi's hunches. Credulity is seduced by his numerous family histories. Disappointment follows discovery of his failure to subject his data to modern statistical analysis. Exasperation attends his neglect of nongenetic factors in the transmission of characteristics from generation to generation. Finally one kicks himself for being again drawn into the old battle of heredity versus environment with more questions raised than answered in this new invasion of the unconscious by the gene. Notwithstanding this severe let-down one must hold in abeyance final judgment of Szondi's intuitions. His test, derived from his genetic theory, if the claims made for it are validated in current studies, may prove to be a contribution of value in personality analysis.

J. SANBORNE BOCKOVEN, M. D.,
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MEDICAL RESEARCH IN FRANCE DURING THE WAR 1939-1945. Edited by *Jean Hamburger.* (Paris: Editions Medicales Flammarion, 1947.)

This book has a limited interest but it covers many fields of medicine in clinical, theoretical, and animal research. It is of special interest because we know the conditions under which the material was collected.

The material in this report includes clinical case reports and clinical surveys that are of interest in the fields of immunology and syphilology. It also includes reports on therapy with the newer drugs both in human subjects and animals and a critical assessment of the values given. There is a very good report on histamine and antihistamine therapy which is full and explicit. It compares antithyroid preparations using aminothiozol and thiourea; their techniques and their value in radiotherapy are discussed and several excellent scientific papers are included. The paper that discusses the role of

phosphatase in calcification of the bone is particularly well done.

In summary, one can find a vast amount of interest in some aspects of medicine, although there will be considerable material with which everyone will not concur.

A. H. Squires, M. D.,
Toronto, Canada.

The Re-Creating of the Individual: A Study of Psychological Types and Their Relation to Psychoanalysis. By *Beatrice M. Hinkle, M.D.* (New York: Dodd, Mead and Company, 1923, 1949.)

This book was first published in 1923. After having been out of print for some years, it was republished in 1949. The author, a doctor of medicine, had practiced psychiatry for some years before she (in 1909) read Freud's *Studien über Hysterie*. Following this she went to Europe to study the new work and knew that she had "found the key" on first discussion with Dr. Jung at Zurich. She had a personal analysis "in the most approved Freudian style." After intensive study of the theories of Freud, Jung, Adler, and others, the author has found herself fundamentally Jungian in her psychiatric concepts and their practice, with partial acceptance of Freudian theories, but with independent elaborations and/or deviations. Upon reviewing the book for republication after some 26 additional years of the practice of psychiatry, she has found that the "validity remains unaltered."

The reader will find the content set forth simply and with the explanatory elaboration that was appropriate when the book was first published. The author's intensive psychiatric study, training, and experience challenge examination of her critical writing. She regards, for example, that Freud's interpretation of dream symbols is "arbitrary and formalized." "For the dream reveals the most urgent need of the personality and presents in symbolic form those psychic necessities which for modern men are quite as urgent and important as physical ones." This reviewer will leave critical conclusions to the reader.

Part I contains chapters on Analytic Psychology—The Development of the Individual; The Child—A Discussion of the Freudian Sexual Interpretation; The Unconscious—Its Dynamic Manifestations in Human Life; and Dream, Phantasy, and Symbolism—Their Present and Prospective Value for the Dreamer.

Part II is devoted largely to the author's psychiatric theories, concepts, and philosophy. She sets forth much of interest regarding the past environmental influences on women and the consequential moulding of the feminine mind.

Glenn E. Myers, M. D.,
Compton, Calif.

Author's Guide for Preparing Manuscript and Handling Proof. (New York: John Wiley & Sons, Inc., 1950.)

Here is a book of instructions for prospective authors that begins at the beginning: preparing the manuscript for the publisher, and takes the author through successive steps in the printing process, offering good advice throughout. The publishers, as one means of keeping printing costs down, aim at better copy and less troublesome proofreading on the part of the author. It is believed, too, that the more a writer understands of the printing procedure the more satisfactory will be his relationship with the publisher.

A chapter on preparing manuscripts for periodicals might properly have come under the title of this book, although outside the province of this publisher. Magazine editors have their special problems: authors who take the trouble to follow a journal's style as to bibliography, for instance, are rare but much appreciated.

An Appendix offering details of editorial style is well worth studying (authors please note the word "data" is plural!), although usage may vary with different publishers. There is an excellent glossary.

For the uninitiated author who contemplates publishing, this manual will be rewarding as well as easy reading.

M. V. L.

Living Wisely and Well. A Discussion of Techniques of Personal Adjustment. Edited by *William B. Terhune, M.D.* (New York: E. P. Dutton & Co., Inc., 1949.)

This small book (95 pages) contains material presented to a neighborhood audience by the Silver Hill Foundation, New Canaan, Conn., in 1948 in a series of lectures on mental hygiene. Dr. Douglas A. Thom dealt with the subject "Mental Hygiene in Childhood"; Dr. Kenneth E. Appel, "Mental Hygiene for the Adult in the World Today"; and Dr. Winfred Overholser, "The Mental Hygiene of Later Maturity." Dr. Zabriskie has provided a Foreword and Doctor Terhune an Editor's Preface. The papers present mental hygiene information in language readily comprehensible to the lay person.

Glenn Myers, M. D.,
Compton, Calif.

The Driving Forces of Human Nature. By *Thomas Verner Moore, Ph. D., M. D.* (New York, Grune and Stratton, 1948.)

Dr. Moore, a Monk of the Order of St. Benedict, has been the Director of Clinic and Nervous Diseases, Providence Hospital, St. Anselm's Priory, Brookland, D. C., and is now in Madrid, Spain. In his preface he states that this book is an attempt at a synthesis of various currents in modern psychological thought. He endeavors to put together the three trends of philosophy, experimental psychology, and psychiatry. He illustrates a few methods of treating disorders of the mind by giving some case studies. He frequently refers to his previous books, *The Nature and Treatment of Mental Disorders, Personal Mental Hygiene,* and *Dynamic Psychology.*

The reviewer does not feel competent to judge the early chapters dealing with "the concept of

psychology" and "the foci of development in psychology." The chief impression obtained was that the author was highly critical of the contribution of American psychologists. For example, discussing William James he says: "In 1861 James settled down to study science, but he was never able to become a scientist. . . . . The *Varieties of Religious Experience* was an unfortunate attempt. James was not equipped by training and sympathetic contacts to understand religious experience." Later he writes: "James' *Principles of Psychology* was an attempt to put together the data of physiology and the new experimental psychology in the light of his own philosophy. He was not satisfied with the result. The reason is not hard to find. His philosophy was inadequate. Unfortunately, instead of correcting his philosophy and working further on the synthesis, he abandoned psychology and went on to develop the inadequate philosophy."

Equally cavalierly the authr treats other psychologists—Boring, Stanley Hall, Freud.

When the author begins to present psychiatric material, he makes statements that are at great variance with the thinking of most present-day psychiatrists. For example, while describing a patient with recurrent attacks of manic-depressive psychosis he reports that ". . . . God withdraws His presence and leaves the soul alone. There often results a state of mind which, in its manifestations but not in its etiology, is closely akin to the pathological depressions."

On page 253, in discussing conflicts in childhood he says: "Those who think that the fear of the whip is the only factor in moral development have too simple a concept of the child mind. Those, on the other hand, who think the fear of the whip is a factor which should be excluded from the moral discipline of youth have too profound a trust in the essential goodness of human nature. It is a factor that should be given its place with all due judgment and discretion in the array of forces which attempt to restrain and direct the blind rush of the sensory impulses to be satisfied at all costs and without regard to the peace and pleasure of others."

On page 312, he reports a clinical case: "A young girl was brought to the clinic because she was supposed to be possessed by the devil. . . . . The reason for the supposition was that she had weird tantrums that prevented her from going to school (defense reaction). The feathers in her pillow were found tied together with peculiar shreds of cloth in the most remarkable fashion. How it occurred to anyone to open the pillow and discover these wonderful "manifestations" I could never learn. I suggested that the pillows be sewed up and never opened again and that if she had any more tantrums she was to be scalded down the back with uncomfortably hot water, given asafetida and put to bed for twenty-four hours. The spells stopped, the feathers were not molested thereafter, and her schooling suffered no further interruptions from these spells."

In the chapter on "Cardiac Psychoneurotic Conditions," he describes an unhappy 26-year-old woman who developed a fear of going out, etc. He goes into detail about what went on in his interviews with her and states that he gave this patient a psychological analysis using free association and dream analysis. From reading the case record, one has the impression that Dr. Moore questioned the patient constantly, made many interpretations, and gave the patient reassurance and suggestion. These techniques are at variance with what psychiatrists usually consider "analysis."

On page 220 in describing another patient with psychoneurotic symptoms, he writes: "The mental origin of her condition was not adequately studied, nor is it always necessary to do so in order to effect a cure."

The reviewer feels that the above cases are sufficient to show that the author's concepts of modern psychiatry are quite different from those of most psychiatrists. The reviewer believes that this book, although it does give some historical survey of early contributions of American psychologists, is not to be recommended as illustrating current methods of treating disorders of the mind.

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